CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

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4 April 1998

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In its mission to ensure that the promotional practices of the pharmaceutical industry are squeaky clean, the Medicines Control Agency is seeking to extend its writ across OTC medicines into areas it seems not to fully understand, and where its moral and legal authority is disputable. As a result, the interim guidelines issued by the PAGB, telling manufacturers how they can promote OTC medicines to 'persons qualified to prescribe or supply' (who now include everyone from pharmacists to petrol pump attendants), lack clarity in some key areas. The nub of the problem is that the guidelines do not draw a clear distinction between 'ethical' and normal retail promotional practices. The PAGB guidelines closely reflect those of the ABPI, which in the main apply to the promotion of prescription medicines to doctors. They, in turn, reflect EU directives which were written with POMs in mind. Doctors are not retailers – they do not buy and sell goods; hence in the past the heavy emphasis on 'buying influence' through extensive sponsorship and lavish entertainment. That, quite rightly, has been stamped out. But trying to apply the same 'preventative medicine' – even if it were necessary – to retail trade practices simply doesn't work very well in some areas. The MCA has not taken into account the commercial nature of a pharmacy business. It is important to understand that there has been no change in the law. What has happened is that the MCA has revised its interpretation. In effectively trashing a promotional code which it approved, and which has worked adequately for four years, the MCA is guilty of gross inconsistency. It is the statutory authority, but with the proposals in MLX 239 and the way it is riding roughshod over industry concerns, the MCA is undermining the voluntary system which has been successful in controlling OTC trade advertising.

CHEMIST & DRUGGIST

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REGULARS

Convenience does not mean desirability rules High Court

The High Court ruling on the pharmacy application in a retail park has redefined the 'neighbourhood' rulings of Justices Tucker and Collins – the Cribbs Causeway and Brent Cross rulings.

The new judgment stresses that convenience for the users of a shopping outlet should not be a concern in considering a pharmacy contract application, as convenience is not the same as desirability. In addition, it should be contract applicants who have the burden of proving any inadequacy of existing pharmaceutical services.

The ruling was made last week by the Hon Mr Justice Turner following a High Court hearing in January (*C&D*, January 24, p6). The judge was considering an appeal brought by Moss Chemists, backed by the National Pharmaceutical Association against the Family Health Services Appeals Authority, which had allowed Boots an NHS contract at the Gemini Retail Park at Warrington.

Handing down his judgment, Mr Justice Turner said there was no evidence that the provision of existing pharmaceutical services in the locality, as opposed to the neighbourhood, was inadequate.

He then dismissed the argument that shoppers expect to find a dispensing pharmacy as they are a regular feature of shopping centres, high streets and even large supermarkets, by saying that the regulations are concerned with the provision of pharmaceutical services, not the convenience of shoppers. "Convenience cannot be the same as desirability," he said.

Mr Justice Turner also said that the regulations place the obligation on the proposed applicant to prove inadequacy of existing provision coupled with the alternative sub-criteria of needs or desirability. "In other words, the intent of the Regulation is that the provision of pharmaceutical services should be demand led, and not led by supply of suitable or convenient premises."

The NPA is "absolutely delighted" with the outcome. Director John D'Arcy added: "This is a great decision for community pharmacy and a victory for common sense. The judgment makes it clear that the absence of a pharmacy from any particular neighbourhood does not automatically mean that the provision of pharmaceutical services is inadequate. Further, it rejects totally out of hand and perfectly logically, the supposition that a busy retail development can generate its own demand."

Charles Russell Solicitors, which represented Moss and the NPA, also points out that the ruling means that the fact that visitors to a retail park or supermarket may not know of the existence of other pharmacies is irrelevant.

Mr Justice Turner concluded that the application hearing for the Gemini Park pharmacy must have a fresh hearing before a differently constituted panel.

Research network funded in Sheffield

Following a bid from local contractors led by LPC secretary Martin Bennett, the Trent Regional Office has agreed to fund a small Community Pharmacy Research Network in Sheffield.

The project aims to establish a network of community pharmacists, skilled in undertaking research. The bid was developed with help from the NPA's professional development team and the RPSGB, who were keen to identify a model that showed community pharmacists' involvement in research. A sum of £42,000 will be provided over a three-year period.

12th OTC Guide published

The 12th edition of the Chemist & Druggist's 'Guide to OTC Medicines' is published with this issue of C&D.

The Guide is intended to be a comprehensive listing of all licensed P and GSL medicines intended for promotion over the counter, as well as licensed homoeopathic and herbal remedies.

For this edition, subscribers may obtain additional copies of the Guide at half-price, £5, by sending a cheque made out to 'Miller Freeman UK' to: Jan Powis, C&D, Miller Freeman House, Sovereign Way, Tonbridge, Kent TN9 1RW. For non-C&D subscribers, additional copies are £10 each. Prices include post and packaging.

Welsh secretary overturns pharmacy application

The Welsh secretary has turned down an application for a supermarket pharmacy by considering neighbourhood services.

Rejecting Bro Taf Health Authority's granting of a contract for a pharmacy in the Asda superstore at Dowlais Top, Merthyr Tydfil, the Welsh Secretary said that the application was "neither necessary nor desirable to secure within the neighbourhood the adequate provision of pharmaceutical services".

The Welsh Secretary had found no evidence to suggest that "the magnitude of the population, within or coming into the neighbourhood for the purposes of working or shopping [is such] that the granting of an additional pharmacy contract is necessary".

He also noted that there was no convenient access to the site on foot and so the proposed pharmacy would be less accessible than the pharmacies in the town near the doctors' surgeries.

The appeal was made by Tim Owen, a pharmacy owner in the town, who was concerned that the HA had granted the application for the Asda pharmacy without taking into account the two nearby pharmacies which he felt provided an adequate service for Dowlais.

Recall problems with GSL packs highlighted

The Royal Pharmaceutical Society has highlighted the lack of recall mechanisms for medicines sold outside pharmacies, following a class one drug alert last week.

The Society's secretary and registrar, John Ferguson, warned of the dangers of medicines remaining on the shelves of other retailers after 25-tablet GSL packs of Mandanol (paracetamol) 500mg tablets were recalled when aspirin tablets were discovered in some packs (*C&D* March 28, p6).

In cases where a recall affects non-pharmacist retailers, these are not contacted directly but via wholesalers, local authorities and trade associations. Media advertising is used to inform the public.

"The current situation is of particular concern because it could affect children's health," he said.

Canvasser censured but Council accepts nomination

A candidate for the Royal Pharmaceutical Society Council elections has been censured for canvassing prior to submitting his nomination form (*C&D* last week, p6).

David Kent had circulated his biographical details in a newsletter to London pharmacy contractors and other LPC secretaries before submitting his candidature. However, at the Society's Council meeting this week, Mr Kent's actions were "deplored".

Although the newsletter said the contents should not be construed as canvassing, "the Council was in no doubt that it constituted canvassing and was a breach of the procedures", said a Society spokesman.

However, Council has accepted Mr Kent's nomination.

- The Council has also approved 17 other nominations. The full list is as follows: Michael Burden, Andrew Burr, Sultan Dajani, William Darling, Marshall Davies, Marion Garner-Patel, Christine Glover, Gillian Hawksworth, David Kent, Andrew McCoig, Clare Mackie, Helen Remington, Melvyn Smith, Jan Sobczuk, Ashwin Tanna, Andrew Taylor, Graham Walker and Nicholas Wood.

Urban and rural areas in list of HAZs

The government has given details of the 11 areas chosen as health action zones.

HAZs were the first 'big idea' in health care to be announced by Health Secretary Frank Dobson last July, after the Labour Government came to power.

The zones will be set up this month with funding of £4 million this year and a further £30m in 1999/2000. The zones will remain active for up to seven years.

The areas targeted are:

- Manchester, Salford & Trafford
- Northumberland
- Luton
- S Yorkshire coalfields (Barnsley, Rotherham and Doncaster)
- Sandwell
- Lambeth, Southwark & Lewisham
- East London & City
- Plymouth City
- Bradford
- Tyne & Wear
- North Cumbria.

HAZs will be encouraged to develop more integrated health care, with a focus towards health promotion rather than service delivery. Long-term targets include a blurring of boundaries between primary and secondary care.

PSNC sets out gross profit calculation

Pharmaceutical Services Negotiating Committee has updated its calculation on standard core dispensing gross profit for 1997/98 to take into account the new discount clawback scale.

In its new look *PSNC News*, the Committee says that when contractors prepare their accounts to March 31 1998, they will need to make provision for the discount clawback of £11 million or £1,335 per contractor. There may be additional liabilities arising from three outstanding reports on Zantac pricing, invoice inspection and reverse generic substitution.

The new calculation is as follows:

	pence per Rx
ingredient cost	847.28
discount	(70.19)
container allowance	6.80
cost of sales	783.89
fees	100.97
professional allowance	33.00
expensive Rx allowance	1.54
Gross profit	135.51
Total payments	919.40
Gross profit %	11.7

Advertising guidelines threaten education

A new stricter interpretation of the rules governing the advertising of OTC medicines to the retailers could see the end of a number of long-standing trade practices.

Corporate sponsorship of awards and educational initiatives through the trade press could be banned, along with industry support for training courses such as *C&D*'s Cambridge Counterpart assistants' training programme and the NPA's Interact course, both of which are supported by OTC manufacturers.

Manufacturer support for wholesaler conventions and the presence of OTC companies at trade exhibitions are also threatened by the new guidelines endorsed by the Medicines Control Agency.

Following the furore last year over the pharmaceutical industry's promotional practices, the MCA has made it clear it intends to tighten up on the application of the medicines advertising regulations. It appears to be trying to impose the rules that apply to the promotion of Prescription Only Medicines to doctors, to the retail market.

To advise OTC manufacturers on how the MCA is now interpreting the legislation, the PAGB last week issued 'interim guidelines'. However, it privately acknowledges that there are a number of clauses about which it is unhappy.

The interim code covers 'persons qualified to prescribe or supply'. The MCA says this should include not only doctors, pharmacists and nurses, but also pharmacy assistants and GSL retailers (eg garages, grocers).

Measures or trade practices which were in existence on January 1, 1993, relating to prices, margins and discounts, fall outside the scope of the code.

Under the revised code, marketing advice given to pharmacists, such as planograms, is regarded as 'an inducement'. As such it should be 'inexpensive and relevant'.

The Code says no gifts, benefits in kind or pecuniary advantage should be offered to pharmacists or assistants as an inducement to supply or buy OTC medicines. However, inexpensive promotional aids and prizes are acceptable. An inexpensive gift is considered to cost no more than £5, and could be a pen, diary or mouse mat. An inexpensive prize is considered to have cost the donor company no more than £100, and no more than a few prizes should be provided per competition. Prizes must be relevant to the recipient's profession or employment, such as magazine subscriptions, training courses and workwear.

Companies will be able to sponsor meetings for pharmacists and their staff, but they must have a clear educational content, and any hospitality must be secondary to the meeting.

- The PAGB has agreed a new consumer code of practice with the MCA. Guidelines are still should be ready to launch on April 24.

Banned ...

- Schemes which enable health professionals to obtain personal benefits, eg gift vouchers, along with the purchase of medicines are unacceptable, even if they are given as alternatives to financial discounts
- Sponsorship of meetings which are mainly of a social or sporting nature
- Competition prizes not relevant to a person's employment, such as microwaves, TV sets, health farm weekends, watches, cordless phones
- Payments to pharmacists for room hire for social events.

... to be clarified

- Corporate sponsorship if it is brand linked or aimed at 'persons qualified to prescribe or supply'. (The ABPI is currently reviewing sponsorship of training/education – PAGB may need to review this area)
- The MCA is currently considering whether listing fees, window display fees and gondola end/counter displays are commercial activities, in which case they fall outside the Code, or inducements, in which case they will be covered by it
- The PAGB is investigating whether wholesaler conventions and trade exhibitions fall under provisions relating to hospitality and meetings.

Pharmacists' educator role highlighted by asthma pilot study

Over half the patients in a pilot study in East Sussex investigating pharmacists' role in asthma management required some form of intervention, according to a new report.

Eleven general practices and 12 community pharmacists took part in the East Sussex, Brighton & Hove Health Authority project, which ran for five months from January 1997.

Pharmacists, who attended a training session prior to the project's start to update their knowledge, helped GPs develop a local protocol based on British Thoracic Society guidelines for identifying asthma patients for review.

Although asthma prescriptions corresponded to guidelines in 87 per cent of cases and were being taken according to guidelines by 86 per cent of the patients, pharmacists intervened or recognised a problem in 58 out of 103 patients on 122 occasions.

Pharmacists educated 45 patients on their therapy, gave compliance advice to 33 and information on dosing and on technique to 22. The impact of the pharmacy advice was not measured.

£76,000 for co-ordinating amounts prescribed

Wiltshire pharmacists are being paid £76,000 to encourage GPs to co-ordinate the quantities they prescribe.

If a prescription has three items, two of which are for 28 days and the other for 42 days, the pharmacist is to be paid £1 for contacting the doctor to bring the third item into line. The pharmacy must first sign an agreement with the GP practice, with 44 agreements in place at the moment, involving 33 of the 90 contractors in Wiltshire.

LPC secretary Ray Jephson says: "The health authority has top-sliced the money off its drugs budget because it could see that the savings would be so great as to make it worthwhile. Another advantage is that it is making doctors and pharmacists talk to each other."

Another major achievement, says Mr Jephson, is that contractors have been granted full membership of Primary Care Clinical Quality Groups. They may apply for funding for any projects aimed at improving clinical practice, particularly if the results can be applied elsewhere in Wiltshire. Devising a practice dressings formulary attracted a grant of £1,000.

"To have access to such funding, as GPs do, is one of the most important things to happen for the future development of pharmacy," he says.

Other initiatives in Wiltshire include:

- early payment for expensive FP10 items, with the initial limit of £500 now being reduced to £300
- the health authority has agreed to put more money into a scheme in which ten strategically placed pharmacies guarantee to stock a list of unusual drugs, mostly for terminal care patients. The list is available to GPs, hospices and community nurses
- a minor ailments project is about to start, involving four contractors and four GP practices at a cost of £10,000. Doctors will refer patients with minor ailments back to the pharmacy in an attempt to educate them that a surgery visit is not always necessary. Protocols are being devised to agree the conditions suitable for referral. The four types of pharmacy will be compared – a Boots branch, an independent, a supermarket pharmacy and one in a health centre
- a smoking cessation pilot, worth £10,000, involves five contractors and four GP practices and will run for two years. The GP will refer those patients most likely to benefit to a pharmacist using the 'Pharmacist Action on Smoking' plan. Pharmacists will be paid a graduated amount based on how far the patient progresses, with monthly targets
- Wiltshire HA has agreed to continue paying hourly rates for rota in 1998-99 of £50 for Sundays and Bank Holidays, with £100 on Christmas Day
- ten pharmacies are running a health promotion pilot, testing consumer response to folic acid displays. It is hoped that, if the results are good, the health authority will fund a wider scheme.

Scottish election results

The Scottish Pharmaceutical Federation has announced the results of its Executive Council election.

The following have been elected: Andrew Taylor – Argyll & Clyde; J Gilmour Milligan –Ayrshire & Arran/Dumfries & Galloway; John Hughes – Fife; Elizabeth McConechy, Elizabeth Roddick and Iain Smyth – Greater Glasgow; Ronald Shiels – Highland/Western Isles; Ian Johnstone – Lanarkshire; George E Allan, Thomas Beattie and Kenneth Black – Lothian/Borders; and Ewen L Jenkin – Tayside.

A new ballot will be held in the Grampian/Orkney/Shetland area as a discrepancy was found in the electoral list prior to the count. Both candidates, David Forbes and Alan Cruickshank, have been invited to attend the next Executive Council meeting as observers.

A vacancy exists for Forth Valley as well as a second representative of Ayrshire & Arran/Dumfries & Galloway.

HA funding continues for joint projects

West Sussex Health Authority is to continue funding joint pharmacist/GP projects and successful applicants can expect an average £1,500 per project, according to pharmaceutical adviser David Phizackerley.

The decision to continue funding follows the publication of a report last month detailing 14 joint projects to improve patient care which took place in 1996/97. Projects were divided into four categories: improving patient compliance, reviewing patient medication, *H pylori* eradication and formulary development.

All six patient compliance projects, which included 'brown bag' reviews and a prescribing review for the elderly, were successful.

Of the three pharmacists involved in patient medication reviews, one is continuing to provide general pharmaceutical support to their project practice while another is still reviewing repeat prescriptions with another surgery's practice nurse.

For more information, contact WSHA pharmaceutical adviser Sue Mills on 01903 708446.

NI general practices benefit from pharmacist input

An advanced training programme for practice pharmacists in Northern Ireland has led to better prescribing and cost savings in general practice, according to a pharmacy practice research group report.

The findings, which were part of a presentation at the pharmacy practice research symposium at the Queen's University of Belfast last week, were a measurement of the success of practice pharmacists in rationalising spending at general practices in Northern Ireland.

Health boards funded practices to employ pharmacists in April 1997. The Northern Ireland Centre for Postgraduate Pharmaceutical Education and Training and the HBs trained the recruits in therapeutics, IT and interpersonal skills, over an eight month period.

GPs, practice managers and practice pharmacists from 22 practices were involved in the study. Medication review clinics were novel to all the practices, while systems such as repeat and generic prescribing were extended to a wider group of practices.

Following the appointment of a practice pharmacist, ten practices have repeat prescribing while nine have practice formularies, 11 generic prescribing, seven medication review clinics and six prescribing data analysis. Before the appointments, six practices had repeat prescribing, practice formularies and generic prescribing, and three had prescribing data analysis.

Findings from other presentations at the symposium include:

- GPs viewed pharmacists' role in formulary development as being most useful in improving prescribing and providing cost advice
- pharmacists have a role in identifying *H pylori* infection making GP referrals and advising patients on eradication therapy where prescribed as part of the management of gastro-intestinal disease, within defined protocols
- there was a high level of acceptability for an angina care model for community pharmacy from angina patients and GPs.

NPA pushes for changes to Misuse of Drugs Act

The NPA has recommended to an independent inquiry into the Misuse of Drugs Act 1971, set up by the Police Federation, that the law should be reviewed to help pharmacists deliver services to drug misusers.

The NPA has put 14 recommendations to the inquiry, covering prescription writing, instalment dispensing, record keeping and storage of CDs, arrangements in nursing and residential homes, waste disposal, supervised methadone administration and arrangements for shared care.

These included a request that regulations be amended to allow pharmacists to dispense and endorse incorrectly written prescriptions following telephone contact with the prescriber.

- The NPA has also responded to a request from Keith Hellawell, the UK anti-drugs co-ordinator, to supply evidence on the community pharmacist's role in the misuse of drugs.

Its recommendations included a suggestion that methadone might not be the most efficient treatment for all opiate-dependent clients. It also urged that resources be re-allocated from central government to health authorities to increase access to syringe and needle exchange services through community pharmacies, and called for changes in the law to allow pharmacists to supply items such as swabs, and water for injections.

Competition Bill delay as CPAG meets Beckett

The second reading of the Competition Bill in the House of Commons, which was expected to be held on April 6, has been delayed.

As *C&D* went to press, the House of Commons said that the reading was not scheduled to happen before the Easter recess. Business has not yet been decided for when the Commons returns on April 20. The delay is thought, in part, to be due to the resale price maintenance amendment supported in the Lords last month.

The Community Pharmacy Action Group met last Wednesday with Margaret Beckett, the President of the Board of Trade. Mrs Beckett accepted that the amendments were legally watertight, said A CPAG spokeswoman, but little else was established. "It's clear they [the DTI] still don't know what they are doing on the issue; that's why it is so important for pharmacists to keep lobbying their MPs," she said.

Emphasising this point, CPAG chairman David Sharpe says lobbying is vital to ensure the application of continued political pressure. Pharmacists in a number of key constituencies have also been sent a petition to be signed by customers urging the Government to maintain RPM.

Cuprofen labelling

Labelling on several batches of Cuprofen Gel 30g and 50g is incorrect, stating that the strength is 5g instead of 5%. Seton Healthcare is not recalling the affected product, but is asking that pharmacists counsel customers appropriately who are purchasing the medication.

Zantac savings

No estimate of savings to the NHS following the patent expiry of Zantac has been made, health minister Alan Milburn said last week. The number of NHS prescriptions for Zantac has fallen slightly from 4.7 million items in 1994/95 to 4.4m in 1996/97. The net ingredient cost fell from £147.6m to £137.2m.

Torex joins Pharmed

Pharmed, the not-for-profit organisation developing an electronic prescribing system, has recruited GP computer supplier Torex Medical Ltd to help develop the system. Torex Medical was formed from the recent merger between Medical Care Systems, which develops clinical and administrative GP systems, and Ambridge Medical Systems. Pharmed has also started beta testing its system.

Care winner

Gita Karia is the first winner of a competition to find the Care Pharmacy Assistant of 1998 organised by Thornton & Ross. Mrs Karia works at the Superdrug pharmacy in Harrow, Middlesex.

NPA pushes NHSE to include pharmacists in PCGs

The National Pharmaceutical Association is urging the NHSE to advise health authorities to involve community pharmacists in primary care groups (PCGs), and to include an assessment of pharmaceutical care needs in local health improvement programmes (HIPs).

It has told Andy McKeon, head of primary care at the Department of Health, that it is disappointed at the limited reference made to community pharmacy in last year's NHS White Paper.

The NPA also says it is essential that pharmacists are included in the NHS Net. The White Paper refers to links between pharmacies and GP surgeries, but it is not clear whether these will be achieved as part of the NHS Net or separately.

"It is illogical to establish two parallel systems ... such action would not be in the best interests of patients," the NPA believes.

- The NPA is urging the NHS Executive to include performance indicators for pharmaceutical care in its new framework for measuring NHS performance.

A consultation document has outlined proposals for a new system of assessing performance. It identifies six areas in which health care providers would be asked to show improvement: health improvement, fair access, effective delivery of appropriate health care, efficiency, patient/carer experience and health outcomes.

The NPA welcomes the idea of using such indicators to improve standards, rather than focusing on activity and financial efficiency.

Examples of indicators that might demonstrate performance in pharmaceutical care include efficiency savings as a result of pharmacists advising on generic prescribing, and improvements in health outcomes following the identification of adverse drug reactions.

In brief

- **Analgesic info** The NPA is to produce a card that members can use to inform customers about the new regulations on pack sizes of analgesics. The new regulations, which come into force on September 16, limit pack sizes to 16 from non-pharmacy outlets, and 32 from pharmacies. Pharmacists will, at their discretion, still be able to sell 100 packs
- **Chairman's Dinner** The Health Secretary, Frank Dobson, has agreed to be guest of honour at the NPA Chairman's Triennial Dinner to be held at the Apothecaries Hall on November 23
- **The NPA's pharmacy planning department** made more than 200 site visits during 1997

NPA Board bids farewell to retiring members

The NPA Board has expressed its appreciation of three long-standing members who retired at the March meeting. David Sharpe (joined 1968), Alan Facer (joined 1980) and Thomas O'Rourke (joined 1967) have notched up a combined total of 79 years service. NPA director, John D'Arcy, presented each with a framed portrait of Mallinson House. The Board also said farewell to three other retiring board members: Alan Cruickshank (chairman 1997/98), Graham Delves and Neil Chapman. Pictured from left are Mr O'Rourke, Mr Facer, Mr Chapman, Mr Cruickshank, Mr Delves and Mr Sharpe

Take inhalers out of Drug Tariff, says NPA

Potential problems with the introduction of CFC-free inhalers have been highlighted by the National Pharmaceutical Association.

The UK Government is committed to the phase out of CFCs in metered dose inhalers by the end of 1999, and manufacturers are to introduce CFC-free MDIs gradually over the next 12 months.

The Association has drawn attention to the fact that, where prescriptions for inhalers are written generically, CFC-free inhalers would only be available in branded form. In such cases, pharmacists would dispense at a loss.

The Association has suggested to the Pharmaceutical Services negotiating Committee that MDIs, such as salbutamol and beclomethasone, be removed from part VIII of the Drug Tariff so that pharmacists could be paid on their endorsement.

The Association is also concerned that pharmacists could be faced with dead-stock if GPs specify CFC-free inhalers on prescriptions. However, it accepts that this is unlikely to be a major problem, since the chief medical officer had stated that there is no clinical reason why patients should not continue to use the CFC-containing inhalers until stocks are exhausted.

Open forum talks for pharmacists from all professional branches

The National Association of Senior Pharmacy Managers is to hold open forum discussions for pharmacists from all branches of the profession, not just hospital pharmacy managers.

Two will be held each year, with representatives invited from official bodies such as the Royal Pharmaceutical Society and the Department of Health. The first will be on May 6 at the Society's headquarters.

NASPM is looking for a professional secretary to act as a central contact for members. The person appointed will probably be a member or a pharmacist who has retired from a hospital managerial post, who would be paid an honorarium. The association's web site is to be used as a major channel of communication, with matters of interest posted as soon as they come to light. The site is: http://www.ps2.com/ns/naspm.

Contract agreed to dispense manufacturer's food supplements

A small pharmacy company has contracted with a major manufacturer to dispense NHS prescriptions for food supplements.

Patients send their prescriptions to the manufacturer who passes them to the pharmacy. The pharmacy sends the dispensed medicines to the patients and submits the prescriptions for pricing in the usual way.

David Reissner of Charles Russell Solicitors, who acted for the undisclosed pharmacy company, said patients had had difficulty obtaining supplies of the infrequently used supplements and had asked the manufacturer for help. The pharmacy specialises in this type of product.

"The pharmacy developed an extended role looking for opportunities to provide an NHS service that was not easily available," said Mr Reissner, who believes it is one of the first agreements of its kind.

OHE publishes managed care report

The Office of Health Economics has published 'Managed care – a model for the UK?', which predicts the increasing use of managed care protocols to improve the quality of care in the UK.

The NHS already utilises the main features of managed care which are the integration of health insurance and health care purchasing functions within one organisation, and the prospective funding of health care.

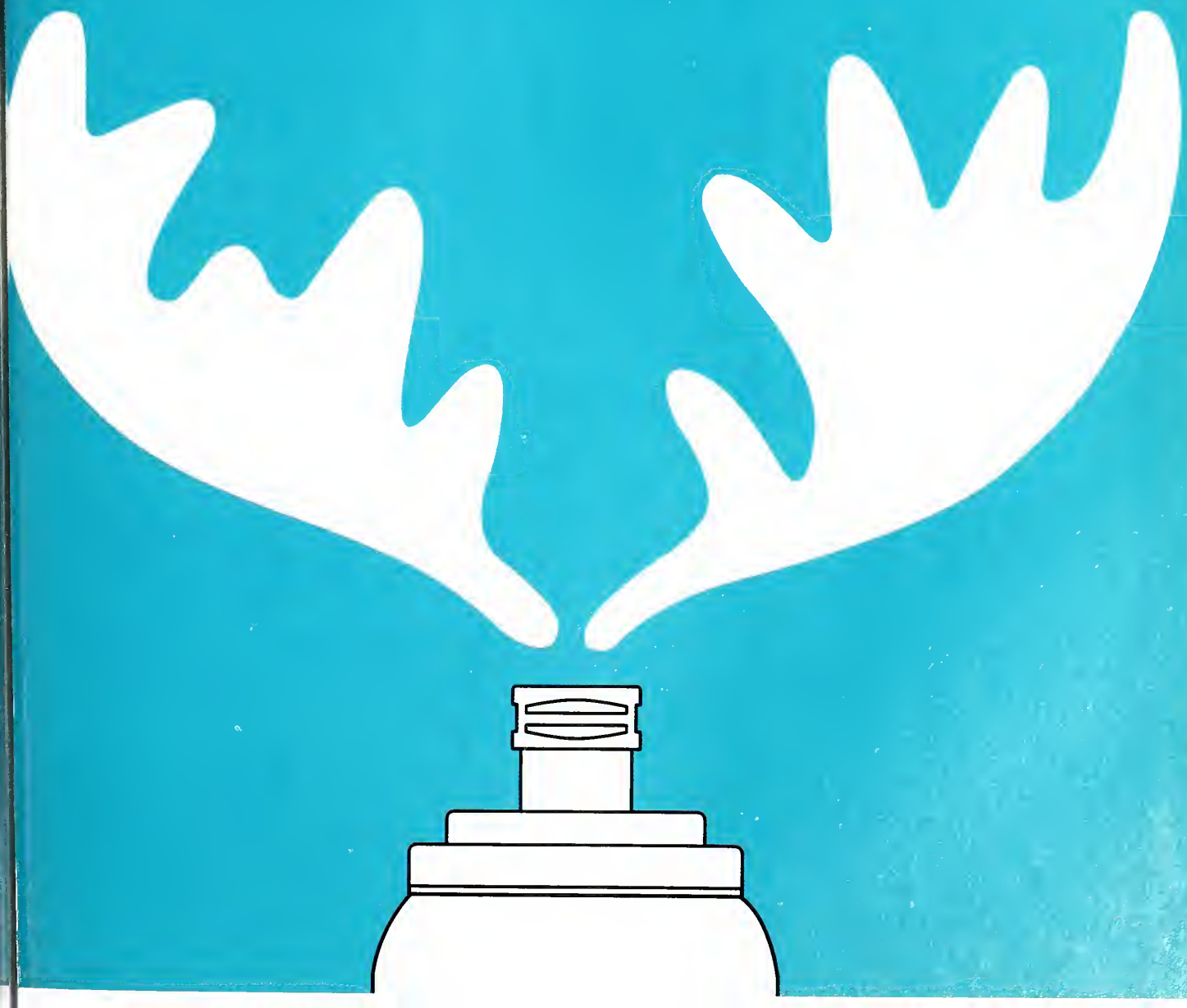
The report defines managed care and explores whether it has a role to play in the NHS or private health sector. For copies of the report (£10 each), contact the OHE on 0171 930 9203.

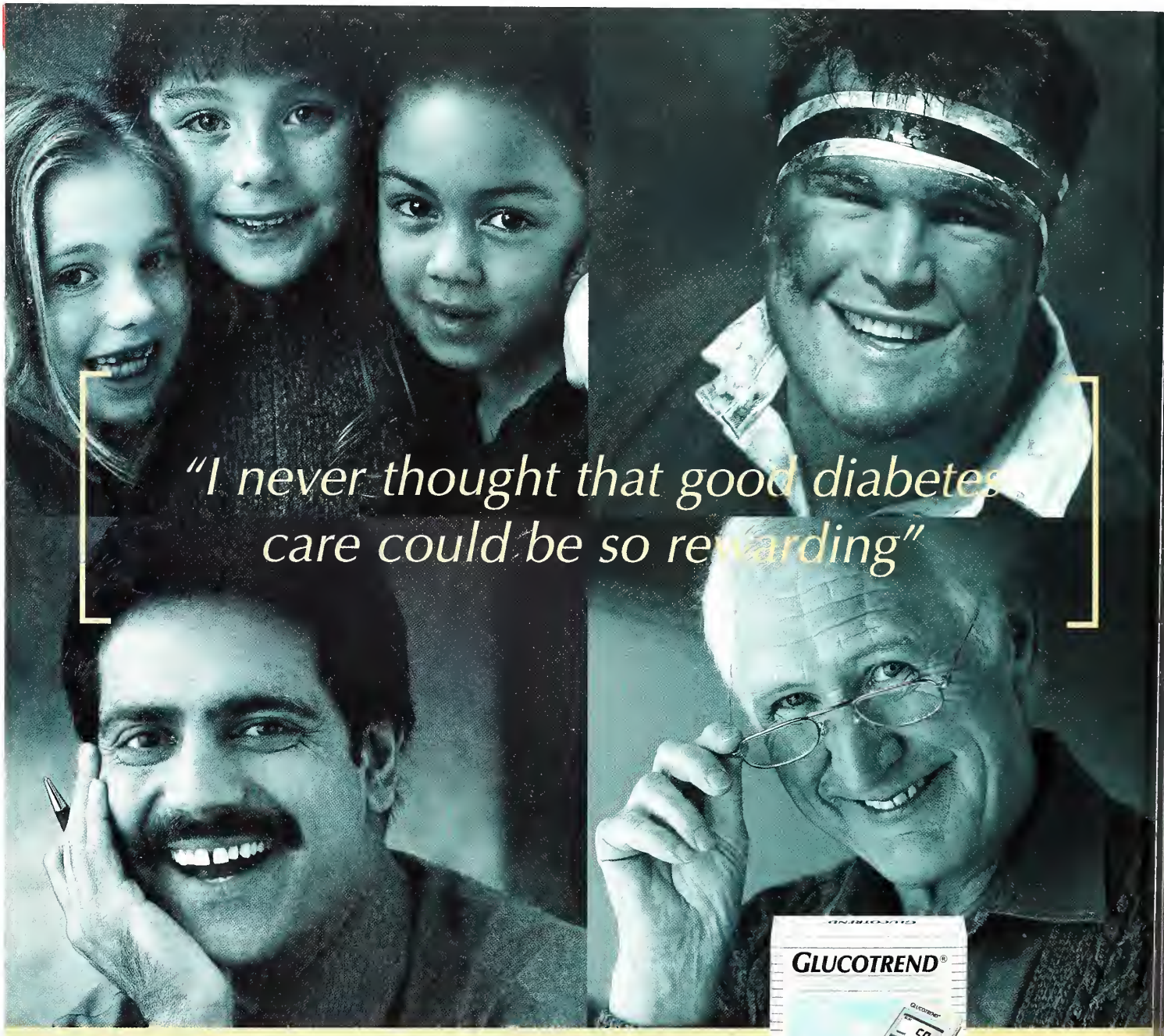
YPG hustings set

The Young Pharmacists' Group will be holding its annual hustings for Royal Pharmaceutical Society Council candidates on April 19.

The hustings form part of the YPG Midlands Regional Conference which will be held over that weekend at the Quality Friendly Hotel, Walsall, West Midlands (off the M6 at junction 10). Non-members are invited to attend the hustings which will be held on the Sunday afternoon.

IT'S GOING TO BE ENOR*MOUSSE*





Virtually pain-free testing

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For further information call FREEPHONE 0800 701000 today
www.boehringer-mannheim.com

boehringer mannheim

GLUCOTREND®
Soft Test System

N IRELAND NOTEBOOK

Pharmacist shortage

When attempting to hire locums, I have experienced the current shortage of pharmacists first hand, and I dread the turn of the century when the problem will become grave. Locums vary in quality, but get more expensive each time! Some provide a caring and professional service, whereas others simply catch up on private reading – it's often a lottery.

No matter how good a locum is, he or she will be unfamiliar with the shop and depend heavily on staff to keep things ticking over. When a locum has a misunderstanding with a customer, the faces of familiar staff often reassure until I return. I have excellent, loyal support staff and turnover is minimal – which I take to mean that they like to work for me.

In common with most independent pharmacies, my staff are mainly part-time. Young women often prefer to work part-time as it is easier to fit in with their domestic situation. I have tried to get two of them to work full-time, but they have resisted, since it would have a significant impact on their social benefits. Both are single parents, both with more than one child.

Lifestyles are very different these days. I do not criticise people for making the best of their sit-

I do not criticise people for making the best of their situation

uation. Labour is doing something positive to address the complex disincentives that exist towards employment, but is still keen to introduce the minimum wage.

My part-time staff work sufficient hours at £3.25 per hour so that what they earn does not impinge on their Social Security payments. A statutory minimum wage may force me to pay perhaps £4.00 per hour. With the hours they work, staff may not get benefit, they may pay NIC and I will have to pay NIC for keeping them.

The concept of a minimum wage, although well intentioned, is naive and will have a negative effect on many of the people that it is intended to help.

The cost of employing pharmacists is rocketing; counter staff will be more costly; a clawback is likely; personal tax is being pulled in earlier and we get a 2.4 per cent increase in the global sum. Why am I being victimised in this way?

Written by a practising Northern Ireland Community pharmacist

Topical Reflections

If the DoH can calculate discount, it can do the same for costs

For the first time, I now understand why discount inquiries take such a long time to determine. In a letter sent recently to contractors, Wally Dove, chairman of PSNC, succinctly explained the complexities of calculating the discount scale and enclosed a copy of the form to be completed by pharmacists participating in the inquiry.

From this information I can see how exacting the calculation is, but this does little to alleviate the real pain of knowing how many thousands of pounds worse off I will be in 1998 than I was in 1997!

However, if I also knew that my costs were being similarly monitored and reimbursed I would not feel so aggrieved. This is an issue that is repeatedly ignored by each successive administration.

I understand the complexity of cost reimbursement and clearly see the administrative logic in capping a global sum and then letting the participants fight over the crumbs, but if the complex calculations on discounts can be addressed, then so can those caused by costs.

To ignore costs while extracting every penny of calculated discounts flies in the face of natural justice.

Despite a recent suggestion from PSNC that we might fund our own cost inquiry, little pressure seems to have been brought to bear upon the DoH to rectify the problem. I suspect this is because costs are a dual problem.

I believe that the true cost of providing the pharmaceutical service is far higher than the global sum acknowledges. Consequently, all contractors would be pleased to agree to this part of an inquiry. It is when costs are apportioned that the problems start.

Discounts are criticised for their variation between contractors, but compared with costs they are uniformly distributed. Costs vary widely from area to area and contractors with lower than average costs have a vested interest in maintaining the status quo.

However, enough is enough. Many contractors are being unfairly treated and their livelihoods are being threatened by the avarice of others. PSNC must now lead a campaign for a comprehensive inquiry into costs, and the determination of a formula that distributes those costs fairly between all contractors.

At last, packaging that works!

I have often complained that the pharmaceutical industry pays scant attention to my problems when new packaging is introduced. Blister packs now dominate my shelves, but inside the box there is invariably far more empty space than tablets.

I had almost despaired of any relaxation of this pressure on my limited storage space when, like manna from heaven, came the new, half the previous size, Carace boxes from Du Pont Pharmaceuticals.

Packaging is always changing, so a plea from the heart to the whole of the British pharmaceutical industry. I do not have rubber walls. Smaller boxes, logical blisters and brand identification on the end of the box, please! If Du Pont can do it, so can you.

Another ethical dilemma?

For once, the National Pharmaceutical Association was first out of the blocks with the offer of 20 per cent commission on travel insurance sold through its members, but this has quickly been followed by a similar scheme from Boots which also includes health insurance (*C&D* March 28, p36).

I have no objection to either scheme, and I have already applied for my pack from the NPA, but as businesses diversify I can foresee a conflict of interest for some employee pharmacists. I am happy to promote travel insurance, but I have always been an enthusiastic supporter of the NHS and would think a lot more carefully before I promoted insurance which possibly undermined that service.

However, I have proprietorial choice. Employee pharmacists rarely have that privilege, and I can see that individual ethical opinions could increasingly conflict with commercial initiatives. Just one more problem for the ethics committee of the Royal Pharmaceutical Society?

SCRIPTspecials

Tavanic joins antibiotic armament

Tavanic (levofloxacin) is a new synthetic fluoroquinolone antibacterial with activity against both Gram-negative and Gram-positive organisms.

The new antibacterial from Hoechst Marion Roussel is active against *Streptococcus pneumoniae* including penicillin-resistant strains. Clinical trials have shown the antibiotic to have a role in managing infections such as community-acquired pneumonia, acute exacerbation of chronic bronchitis, acute sinusitis, skin and soft tissue infections, complicated urinary tract infections and pyelonephritis.

The dose depends on the type and severity of infection and the sensitivity of the pathogen. The tablets are given at a once or twice a day frequency, to a maximum duration of 14 days.

Tavanic comes as 250mg tablets (5, basic NHS price £7.77; 10, £15.54) and 500mg tablets (5, £13.90; 10, £27.80) and 500mg iv solution for infusion (100ml bottle, £28.39).

Hoechst Marion Roussel Ltd.
Tel: 01895 834343.

Optilast eye drop antihistamine

ASTA Medica has launched azelastine antihistamine in an eye drop formulation.

Optilast (6ml bottle, basic NHS price £7.20) is a clear, aqueous ophthalmic solution containing azelastine hydrochloride 0.05 per cent (0.015mg antihistamine per drop). It is indicated for the symptomatic treatment and prevention of seasonal allergic conjunctivitis with relief achieved within 10 minutes of application.

The recommended dose for adults and children over 12 years old is one drop in each eye twice a day, but the frequency can be increased to four times a day in cases of severe allergy. Treatment should be continued for as long as relief is required. Optilast should not be used with contact lenses.

Studies have shown Optilast to be effective against the ocular symptoms of hay fever such as itching, redness, swelling of eyelids and watery eyes.

ASTA Medica is also the maker of Rhinolast, an azelastine-containing nasal formulation.

ASTA Medica Ltd.
Tel: 01223 423434.

Rohypnol to become Schedule 3

The Home Office has announced further restrictions on the supply and possession of flunitrazepam, marketed by Roche as Rohypnol.

From May 1, the Class C drug will move to Schedule 3 of the Misuse of Drugs Regulations and will require safe storage. As *C&D* went to press, the Home Office could not clarify whether there will be an exemption from prescription details or handwriting requirements like temazepam. However, it stated that licences will be required for import or export. Penalties for unlawful possession will be up to two years in prison, an unlimited fine, or both.

Concern has been expressed that the drug may have been used in cases of 'date rape' where the victim's drink had been spiked. Roche fully supports the Home Office's action and a re-formulation of Rohypnol, containing a blue dye to deter spiking of drinks, was approved in January.

The new regulations also bring six other drugs under the control of the Misuse of Drugs Act 1971. From May 1 etryptamine becomes Class A, methcathinone and zipeprol become Class B and aminorex, brotizolam and mesocarb become Class C substances.

Mizollen antihistamine targets nasal congestion

Mizollen (mizolastine) is a new highly selective non-sedative antihistamine from Lorex Synthélabo which is particularly effective in relieving the nasal symptoms of hay fever.

Mizolastine has been shown to be more selective for H1 receptors than existing non-sedating antihistamines and of particular benefit in relieving nasal congestion and obstruction in hay fever. Antihistamines in general are less effective at tackling 'blocked nose' and additional medication such as decongestants and topical corticosteroids are often needed to bring relief.

The new antihistamine also lacks affinity for H2, H3, muscurinic and serotoninergic receptors and has poor blood-brain penetration which means mezolastine has a low side profile with no drowsiness or impairment of concentration at the recommended dose.

Incidence of cardiac problems is also low. Trials have shown no effect on cardiac repolarisation even at 7.5 times the recommended dose and no cardiac arrhythmias. Cardiac risk is thought to be similar to that of cetirizine. However, mizolastine is contraindicated in patients with a history of cardiac disease and arrhythmias.

As well as the indication for seasonal allergic rhinitis, mizolastine is also licensed for perennial allergic rhinitis and urticaria.

The daily dose for adults and children over 12 years is one 10mg tablet once daily, and relief is usually seen within an hour.

Concomitant use with macrolide antibiotics or systemic imidazole antifungals is contraindicated.

The basic NHS price for 30 tablets of Mizollen is £8.95.

Lorex Synthélabo Ltd. Tel: 01628 501200.

Clickhaler aims to improve compliance

Evans Medical has launched a new dry powder salbutamol inhaler which has been designed to improve patient compliance.

Even with written instructions, as many as half of patients do not use their metered dose inhaler properly, largely due to problems co-ordinating actuation of the MDI with inhalation. Asmasal Clickhaler overcomes this problem by making the two steps distinct – a click to prime the inhaler, then a breath-actuated inspiration of the dry powder. Double-dosing is not a problem as a safety mechanism ensures that only one dose is in the inhalation channel at any one time.

A dose counter counts the doses up to 200 with the final ten doses highlighted to alert the patient that a new inhaler is required. Once the final dose has been administered the device automatically locks so it cannot be used when empty – a problem which can occur with conventional MDIs.

Asmasal Clickhaler delivers 95mcg salbutamol per actuation, so its dosage (one or two puffs up to four times daily) is equivalent to that of a salbutamol-containing MDI, making conversion to the new device easy. The clinical efficacy of the Clickhaler is independent of respiratory flow rate and can be used in patients with mild moderate or severe stable respiratory disease, unlike MDIs. It can be prescribed to adults and children over five years.

Asmasal Clickhaler (200 dose) has a basic NHS price of £6.32.

Evans Medical Ltd.
Tel: 01372 364000.

Zacin – the cream of green chillies for osteoarthritis

Zacin is a new topical analgesic cream for the relief of pain associated with osteoarthritis.

Zacin Cream contains capsaicin 0.025 per cent derived from green chillies (capsicum fruit). The cream should be applied to the affected area four times a day, avoiding contact with sensitive areas such as eyes. Relief is normally experienced within a week of treatment, but is increased with regular use over two to eight weeks. The cream is not suitable for children.

Bandages should not be applied on top of the cream. If the condition recurs or worsens, users should be referred back to the prescriber.

Zacin Cream is available in a 45g tube at a basic NHS price of £15.04.

Bioglan Laboratories Ltd.
Tel: 01462 438444.

This summer follow the sun

Zirtek gives fast and powerful relief of hayfever symptoms[1]

Zirtek is not significantly metabolised [illegible] and provides fast and effective relief of hayfever symptoms.

Zirtek has a broad safety profile[2,3]

Zirtek is a selective H [illegible] effects on other receptors [illegible] drowsiness, no impairment [illegible] significant drug interactions [illegible]

Zirtek has no known [illegible] even after more than [illegible] prescribed world wide [illegible]

Double action

Zirtek™

cetirizine

Help your hayfever patients be themselves

CRIBING INFORMATION: Each white, oblong, scored, film-coated tablet engraved ntains 10 mg cetirizine dihydrochloride. **USES:** Treatment of seasonal and perennial and chronic idiopathic urticaria. **DOSAGE AND ADMINISTRATION:** Adults and n aged 12 years and over: One 10 mg tablet daily. In renal insufficiency halve the dose to 1/2 tablet) daily. **CONTRAINDICATIONS:** Hypersensitivity to constituents. Avoid use nancy and lactation. **PRECAUTIONS:** Do not exceed recommended dose, particularly g or operating machinery. **DRUG INTERACTIONS:** To date there are no known medications with other drugs. As with other antihistamines avoid excessive alcohol consumption. **SIDE EFFECTS:** Mild and transient drowsiness, headache, dizziness, agitation, dry mouth and gastrointestinal discomfort have been reported. **PACKING, PRICE:** Pack of [illegible] tablets = £4.25. **LEGAL CATEGORY:** P. **PRODUCT LICENCE NUMBER:** 5221/0001. **PRODUCT LICENCE HOLDER:** UCB SA Pharmaceutical Sector, Avenue Louise, B-1050 Brussels, Belgium. **MARKETED BY:** UCB Pharma Limited, Watford, Herts, WD1 1DJ. **DATE OF PREPARATION:** February 1998 UCB-Z-98-23

References: 1- Day JH et al., Ann Allergy Asthma Immunol 1997; 79: 163-72 2- Snyder S et al., Annals of Allergy 1987; 59: 4-8 3- Linquist et al., The Lancet 1997; vol 349:1322 4- Passalacqua et al., EACCI Position Paper. Allergy 1996; 51 [illegible]

Pharma

For further information please contact: UCB Pharma Limited, Star House, 69 Clarendon Road, Watford, Herts, WD1 1DJ Telephone: (01923) 211811 Fax: (01923) 229002

"GREAT BUSINESS" AWARDS

Sponsored by UniChem

Independent pharmacy faces many challenges today. Competition has never been fiercer, be it from the High Street, Supermarkets or indeed other independents. To survive today, the independent pharmacist not only has to perform his traditional role but also has to master many areas of business where he or she has no formal training. Those pharmacists who can find a point of difference will be those who succeed. And, there are a great many who have the flair and enthusiasm to look for and develop ideas that will ensure they have a more than healthy future.

To reward and encourage pharmacists who have looked beyond their traditional role, UniChem, in conjunction with Community Pharmacy magazine, are delighted to launch their "Great Business" Awards scheme. In the year that the NHS celebrates its 50th Anniversary and UniChem its Diamond Jubilee it seems wholly appropriate to introduce an awards scheme that rewards initiatives that will drive the pharmacy business well on into the new Millennium. The awards cover a broad spectrum of ideas all of which UniChem, with 60 years of experience of pharmacy, are well positioned to appreciate.

Community PHARMACY
For Pharmacies in the New Age

CATEGORY 1

TRAFFIC GENERATING INITIATIVES

Increased footfall through the pharmacy is a key to improving business. Motivating and encouraging consumers to use their local, independent pharmacy rather than a grocery supermarket is a continuing battle.

This category will look for ideas that include marketing in the local community, special promotions and advertising, imaginative use of point-of-sale and window displays and linked selling of products and services.

It could also encompass initiatives such as the introduction of homeopathic products, the setting-up of a baby clinic or a private pregnancy testing area.

In other words, any ideas that bring more people into the pharmacy.

Entries should, wherever possible, be supported by turnover comparisons (before and after) or voucher redemption if some sort of coupon device is used.

YOU CAN WIN AN AWARD

The "Great Business" awards will be presented at a special dinner to be held in November of this year. A winner will be nominated for each category and there will be a further award for the best overall entry.

The winning entries will be published in Community Pharmacy magazine and Chemist & Druggist. The overall winner will receive 2 free places on UniChem's

THE AWARD CATEGORIES

There are 4 different Award categories and pharmacists are encouraged to enter as many of the categories as they feel they can.

CATEGORY 2
BUILDING RELATIONSHIPS IN THE COMMUNITY

The establishment of a strong local presence is crucial to the independent pharmacy.
A feeling that the pharmacy can answer all the consumer's health needs will ensure regular and repeat business.
This category will look for initiatives that are designed to strengthen a pharmacy's position in its local community.
This category might well require the involvement of all the pharmacy staff in identifying the needs of the community.
What services would benefit the community?
What age profile is the community and what effect does this have on the pharmacy?
What action has been taken to address the issues relevant to the community and how has this benefited the pharmacy?

CATEGORY 3
INNOVATIVE NEW RETAIL LAYOUT

We have all been into shops which do not encourage consumers to look around, to fully appreciate what is on offer. Independent pharmacy is no different in this respect.
Great care and attention should be given to ensure that the pharmacy is "user-friendly", that primary traffic areas are easy to access and that the consumer feels welcome.
This category is looking for initiatives that have positively affected the layout of the pharmacy.
This could be anything from a complete revamp to the new positioning of a product sector to redirect customer flow.
Before and after pictures will obviously clearly outline the changes and it will be interesting to see what can be achieved regardless of financial outlay. A small investment may well generate a sizeable return.
A new look pharmacy may well attract a completely new mix of customers.

CATEGORY 4
RECENT ACQUISITIONS

This category looks to reward those pharmacists who within the last 2 years have taken the bold step of either acquiring their first pharmacy or have purchased additional pharmacies.
Whether first or 20th, a new owner for a pharmacy faces fresh challenges and will need new ideas.
We are looking for initiatives that have been introduced to improve pharmacy performance, widen a pharmacy's catchment area or launch new services that had not been available before.
Initiatives that a pharmacist should consider in trying to build a new business.

SPECIAL AWARD - PHARMACEUTICAL MANUFACTURERS

This special award gives the independent pharmacist the opportunity to vote for the manufacturer who in their opinion is the most supportive of pharmacy.
Opportunities to vote will be given in Community Pharmacy, Chemist & Druggist and via the UniChem salesforce.

99 Convention with the individual tegory winners receiving £1,000 towards e holiday of their choice.

THE JUDGES

e panel of judges will be representative the Pharmacy Industry in its broadest nse. It will include Peter Curphey, sident of the Royal Pharmaceutical ciety, Neil Williamson, NPA Head of nning, Martyn Ward, Sales & Marketing fector of UniChem and Ailsa Colquhoun, Editor of Community Pharmacy. All of whom will bring a great deal of knowledge and experience to the judging of entries.

HOW TO ENTER

Enclosed within this issue of Community Pharmacy and also within the 4th April issue of Chemist & Druggist is an entry form. All entry forms must be submitted by 30th September 1998.
Each month Community Pharmacy magazine will publish a reminder of the different categories and provide some insight as to what the judges are looking for.
Entries should be submitted to:
Great Business Awards, UniChem, UniChem House, Cox Lane, Chessington, Surrey KT9 1SN.

DIAMOND ANNIVERSARY

1938 UniChem 1998

COUNTERpoints

A fresh approach for Sure

Elida Fabergé is launching a new variant in its Sure Intensive antiperspirant deodorant range.

Targeted at 18-24-year-old women, Cotton Fresh is fragranced with the scent of fresh clean cotton.

Developed by fragrance consultant Ann Gottlieb, it combines fruity-top notes with a soft warm, base. The formulation is pH balanced and dermatologically tested.

The variant is available in two sizes of aerosol, Ultra Dry Cream and a new big ball roll-on.

The big ball applicator is designed to fit the average underarm with one stroke to give total coverage. Retail prices range from £1.29 for the roll-on to £2.39 for Ultra Dry Cream.

The launch will be supported by a £2.5 million media package which includes TV and press advertising.

● New, too, is Sure Sport for Men which has a fresh, sporty fragrance. It comes in petrol green packaging to enhance its masculine image.

The range includes two sizes of aerosol, Powerstick and big ball roll-on. Retail prices range from £1.29 for the roll-on to £2.19 for Powerstick.

The launch will be supported by a £4m marketing campaign which includes TV advertising and a sampling programme.

Throughout the summer, a Sure Sport for Men roadshow will be touring the country inviting men at railway stations and shopping malls to try and score a goal against a professional goalkeeper.

● The big ball applicator has also been introduced in three variants of Sure Sensive (£1.39) and seven variants of Sure Intensive (£1.29).

Elida Fabergé.
Tel: 0181 481 6000.

Gillette helps customers keep cool

Gillette is launching three new fragrances in its Right Guard and Natrel Plus antiperspirant deodorant ranges for summer.

A light, fresh fragrance called Oshia is the latest Natrel Plus fragrance. Targeted at young females between 16 and 24, it is packaged in a vibrant orange bottle and retails at £1.99 (170ml aerosol), £1.25 (roll-on) and £2.05 (Silken Solid).

The new Natrel Plus Silken Solid range contains natural silk for effective protection with a smoother application.

Xtreme and Topaz are the two new fragrances in the Right Guard range. Xtreme is an overtly masculine fragrance which comes in black and silver packaging. Topaz is a light, feminine fragrance in silver packaging designed to appeal to women. Retail prices are £2.09 (200ml aerosol) and £1.25 (roll-on).

Both Right Guard and Natural Plus now feature a new big ball roll-on to make application easier and more thorough. The bigger ball will replace all existing roll-ons and as part of this initiative these products will be available in reduced outer packs of six.

Gillette is investing £7 million in an advertising and marketing campaign for Natrel Plus and Right Guard.

Natrel Plus advertisements will feature the new Oshia variant in the women's press over the summer months. In-store activities targeting younger women are also planned. In June/July, Right Guard will again be supported by the successful TV campaign featuring Des Lynham.

Gillette UK Ltd.
Tel: 0181 560 1234.

Elizabeth Arden introduces a new bodyguard

Elizabeth Arden will be launching a new anti-ageing body product on May 25.

Ceramide Firm Lift Body Lotion is formulated with a combination of retinyl linoleate (vitamin A derivative) and ceramide 6, which is a rich moisturiser.

The product also contains lactic acid (an alpha hydroxy acid) to improve the appearance and tone of the skin.

It is especially suitable for use on the 'V' area of the chest, the abdomen, buttocks and thighs.

Presented in a pump dispenser with a frosty peach exterior, it will retail at £23.00 (200ml).

● The company is also introducing a new problem-solving Visible Difference skin care range in April. It includes product solutions for dry skin and special skin care needs. Prices range from £12.95 to £39.00.

Elizabeth Arden Ltd.
Tel: 0171 574 2700.

Palmolive goes fruity in the shower

Colgate-Palmolive is launching a new range of Palmolive shower gels containing vitamins and fruit extracts.

The three fruit gels contain gentle cleansers to remove dirt and bacteria and fruit extracts to cleanse away dead cells.

Renewing Gel contains grapefruit and papaya extracts which gently cleanse while encouraging regeneration to help maintain clear, smooth and radiant skin.

Toning Gel contains extracts of kiwi and mango which have a mildly astringent effect that helps to tone and firm the skin.

Revitalising Gel contains rose water essence and visible bubbles of vitamin E and peach kernel oil known for their moisturising properties.

Presented in transparent 250ml packs, the vibrantly coloured gels retail at £1.99.

The launch will benefit from a £3 million marketing support package for the Palmolive brand this year, which includes regional TV advertising.

Colgate-Palmolive (UK) Ltd.
Tel: 01483 302222.

Revlon hits the street with hot metal

Revlon is introducing new lip and nail products in its Street Wear range this month.

A new range of nail glitters comes in five colours – Hologram (silver), Midas (gold), Psychedelic (pink), Groovy (mauve) and Disco (blue). New lipsticks are opalescent FX Icicle and iridescent FX Flash, plus Jelly and Blood. All products retail at £3.95.

Revlon International Corporation.
Tel: 0171 629 7400.

Bags of style from Polo Sport

Prestige & Collections is introducing two Ralph Lauren gifts with purchase promotions on April 11.

A stylish men's Polo Sport ruck sack and a Polo Sport Woman scuba bag come with purchases worth £30 or more from the Polo Sport fragrances and skin fitness collections. The offer will run while stocks last.

Prestige & Collections Ltd.
Tel: 0181 979 6699.

Here's how serious we are about selling our meters in your pharmacy!

Until the 30th June 1998 we will reimburse you £20 for every ONE TOUCH® meter sold. This means your customer pays only £9 for th BASIC™ or £29 for the Profile™. We expect you will sell quite a few!

Our national sales teams are visiting diabetes clinics in both hospitals and general practice, demonstrating the meters, explaining the offer and where it is available....that can mean your pharmacy!

For a POS pack and further details on how you can participate in this exciting promotion phone now.

LifeScan Customer Care Freephone:
0800 121200

LIFESCAN
a Johnson & Johnson company

98.01/

A dual approach to symptoms

Imodium Plus, being launched this month, alleviates diarrhoea and other symptoms that often accompany it, such as cramping pain, bloating and flatulence.

Each chewable tablet, which can be swallowed without water, contains loperamide 2mg and simethicone 125mg (6, $3.45). In trials, the combination produced better relief of symptoms than the individual ingredients alone. Simethicone disperses trapped gas bubbles which are produced when increased gut motility delivers more nutrients to the colon where they are broken down by bacteria. The surfactant effect of the simethicone also seems to improve the distribution of loperamide, enabling it to act more quickly.

Surveys have shown that 50-80 per cent of diarrhoea sufferers experience other symptoms of abdominal discomfort. Johnson & Johnson MSD Consumer Pharmaceuticals anticipates that Imodium Plus will eventually supersede Imodium.

A Pharmacy-only medicine, the new product will be supported by direct mail, television advertising and in-store educational and promotional material. A training pack, 'The complete works', is available for pharmacists. A 'Better to treat' public relations campaign aims to inform health professionals and consumers about the latest research into diarrhoea.

J&J MSD Consumer Pharmaceuticals. Tel: 01494 450778.

Organic message for Selenium Bonus supplement

Lifeplan Products has repackaged its organic Selenium Bonus antioxidant supplement.

The product now comes in tamper resistant blister packs which highlight the message that it is a yeast-free, organic supplement.

Available in packs of 30 and 90 tablets, it comes with a merchandising tray and an additional PoS information board.

Lifeplan Products. Tel: 01455 556281.

Independent drive

SCA Hygiene has appointed Ceuta Healthcare to develop its business within the independent chemist sector. Its brands include Bodyform, Scotties Facial Tissues and Handy Andies pocket-pack tissues.

Ceuta Healthcare Ltd. Tel: 01202 780558.

Life's a beach

Procter & Gamble will be supporting its new Cover Girl 'Life's a Beach' collection with cinema advertising from mid-April to mid-June.The commercial features reggae by Ziggy Marley and the Melody Makers.

Procter & Gamble Ltd. Tel: 0191 279 2000.

Eat, drink ...

Canderel low-calorie sweetener will be supported by a £2 million TV and poster campaign from April 13 until the end of May.

Chemist Brokers. Tel: 01705 222500.

DEET-free ingredient for Autan

Autan is being relaunched with a new DEET-free insect repellent.

Developed by Bayer, Bayrepel is more effective than DEET (at the 20 per cent used in existing Autan products) and acts for up to 70 per cent longer. The new ingredient is also non-sticky and odourless.

Bayrepel is contained in two new products, Autan Active and Autan Family. Offering up to eight hours protection, Autan Active is suitable for people travelling abroad or involved in outdoor sports. There are three formats – body spray 100ml, pump spray 100ml and stick 50ml. Autan Family, which gives up to four hours protection, comes as a lightly-perfumed moisturising lotion containing aloe vera (100ml). It is particularly suitable for children, although all the products are safe for children over two. All retail at $4.99.

Bayer Consumer Care is spending much more on the brand this year than last. Consumer advertising starts mid-summer.

Bayer plc Consumer Care. Tel: 01635 563000.

Cold comfort throughout the year

Mars Confectionery is extending its Coldline initiative during the rest of the year.

The on pack Tunes Coldline telephone number will now appear on a further 3 million packs of Tunes.

Over 35,000 calls have been made to the Coldline since its launch last November.

Callers can access health tips and regional weather news as well as requesting a copy of the Tunes Cold Information pack.

The aim of the Coldline is to help encourage more people to consider self-medication when they have a cold.

Mars Confectionery. Tel: 01753 550055.

RPR gives boost to Dioralyte Relief

Rhône-Poulenc Rorer is supporting its recently introduced Dioralyte Relief, which has been shown to provide more rapid relief of diarrhoea than the original product, with advertising in the mainstream and parenting press.

A two-month educational campaign for health care professionals, including GPs, will include sampling.

A campaign aimed at doctors is thought to be important, after a recent survey showed that, while GPs were aware of the need for rehydration, many recommended water or soft drinks which fail to replace lost electrolytes. Orange juice can make dehydration and diarrhoea worse because of its high osmolarity.

The original Dioralyte will remain on the market as it is suitable for babies under three months as well as athletes and fire-fighters who take it as an electrolyte replacement/ rehydration solution.

Rhône-Poulenc Rorer Ltd. Tel: 01732 584000.

Bioral mouth ulcer gel relaunched

This month sees Seven Seas relaunching Bioral mouth ulcer gel under the Merck Consumer Health banner.

Bioral is the one of six OTC brands acquired from Smithkline Beecham last September.

The relaunch of the other five brands – Phensic, Actal, Calfig, Milpar and Vykmin – will be staggered throughout the year.

Merck Consumer Health products. Tel: 01482 375234.

ON TV NEXT WEEK

Clearblue Home Pregnancy Test: G, C, LWT, CAR, C4, Sat

Imodium: All areas

Listerine antiseptic mouthwash: GTV, STV, G, A, M, ITV, Sat

Pearl Drops: C4, C5

Poli Grip: All areas except CTV, W, LWT, GMTV, TSW

Propain: All areas except GTV, U, CTV, W, CAR, TSW

Simple skincare: ITC, C4, C5, Sat

Slim Fast: All areas

Solpadeine: GTV, B, G, Y, A, W, TT, TSW

Vicks New Vaposyrup: GTV, STV

Wella Experience: Sat

Wella Shock Waves: Sat

Wilkinson Sword FX Performer: GTV, U, STV, Y, C, A, M, LWT, TT, C4, Sat

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TSW** TV South West, **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

New formula to 'hook' mums into Milupa

Milupa will be launching a casein-based infant milk formula containing LCPs (long chain polyunsaturated fatty acids) in May.

Aptamil Extra with Milupan will be the first Milupa casein-based infant milk formula for hungrier bottlefed babies to include LCPs.

The company believes LCPs in a casein-based starter milk will provide the 'hook' for mothers to enter the brand.

The new milk formula will join Milupa's Aptamil First with Milupan, Milumil and Forward Follow-on Milk.

All four products will be relaunched in May with a new pack design featuring a series of toy graphics to reinforce a developmental brand image.

The eye-catching packs feature clearer, factual nutritional information enabling parents to understand product benefits and differences more easily.

Aptamil Extra with Milupan will retail at £7.29 (900g) and £3.99 (450g).

- In an attempt to revive the dry baby foods market, Milupa is relaunching its baby foods range with an appealing new look this month.

The packaging emphasises the brand message of 'healthy, balanced nutrition' and 'convenience'. A picture of a baby now appears on the pack.

Retail price is £1.85 for Baby Meals (125g), Pure Baby Rice (100g) and Baby Sauces (120g).

This month sees the launch of a £3.5 million marketing support programme for the Milupa brand including TV and press advertising and direct mail.

The brand will be advertised on TV in a series of eight three minute mini-programmes to be screened on Channel 4 from May.

New PoS material is available.

Milupa Ltd (division of Nutricia).
Tel: 01225 768381.

Colgate window challenge

Colgate-Palmolive is helping pharmacies to gear up for National Smile Week (May 18-24) with a free merchandising kit.

The company will also be offering a prize of £2,500 worth of Colgate oral care products or one of five runners-up prizes of 1,000 air miles. More details will be published in the next issue of *C&D*.

Colgate-Palmolive (UK) Ltd.
Tel: 01483 302222.

Healthy outlook

Health Perception's products will be stocked by Unichem from this month. Its range includes Seredrin and Tri-Chi.

Health Perception.
Tel: 01344 890115.

Fat chance

Swiss Health has repackaged its Fat Magnets chitosan supplement designed to help remove unwanted fat from the diet. Colourful new packaging focuses on natural health. Retail prices are £18.95 (100 capsules) and £49.95 (300 capsules).

Chemist Brokers.
Tel: 01705 222500.

Bottoms up

Kimberly-Clark is supporting its new Huggies Air Dry Nappies with an 'Eyesites' poster campaign in 400 baby changing rooms in shopping centres and motorway service stations.

Kimberly-Clark Ltd.
Tel: 01732 594000.

Alton Towers link for Durex Oblivion

LRC Products has teamed up with Alton Towers theme park to launch Durex Oblivion – its new orange flavoured condom.

Oblivion is the name of a new white knuckle ride at Alton Towers which features a terrifying face first vertical drop.

Packaging for the new condom features the Oblivion logo and PoS material reflects the vivid orange and black colours of the ride.

Sold in packs of one, it retails at £1.00.

- Alton Towers will be launching a range of Oblivion unisex body sprays exclusively through Boots in May.

LRC Products Ltd.
Tel: 01992 451111.

Sticking together with C&C Optical

C&C Optical is launching stick-on lenses which convert sunglasses into reading glasses.

An American idea, OPTX 20/20 are plastic, half moon shaped lenses which can be easily applied to any sunglasses.

Available in ten strengths of magnification, the lenses are suitable for occasional use with sunglasses and are not intended to replace prescription glasses.

Retail price is £20.95.

C&C Optical.
Tel: 01432 358050.

Kid's oral health kit is as easy as ABC

Smithkline Beecham is introducing an oral health starter training kit designed to appeal to mothers of 0-6-year-olds.

With the theme 'As easy as ABC', the kit combines Macleans Milk Teeth toothpaste (17ml) with a newly designed Milk Teeth toothbrush.

It includes a leaflet with coupons worth £0.50 to encourage future purchases.

Available in mid-April, the kit is BDA accredited and will retail at £2.19.

A £500,000 advertising campaign will support the launch.

Smithkline Beecham Consumer Healthcare.
Tel: 0181 560 5151.

Are other

PRODUCT INFORMATION: NUROFEN ADVANCE. Tablet containing: 342 mg of ibuprofen lysine (equivalent to 200 mg ibuprofen) **Also contains:** Povidone, Microcrystalline Cel Magnesium Stearate, Hydroxypropylmethylcellulose, Hydroxypropyl Cellulose, Titanium Dioxide (E171). **Indication:** For the relief of mild to moderate pain, including headache, rheuma muscular pain, backache, neuralgia, migraine, dental pain, dysmenorrhoea, feverishness, symptoms of cold and influenza. **Dosage:** In Adults and Children 12 years of age and older – Initia 2 tablets with water followed by 1 or 2 tablets every 4 hours if necessary. Do not take more than six tablets per day. **Precautions and Warnings.** History of hypersensitivity to any compo this product or to any non-steroidal antiinflammatory drug. Cross reactions may occur with this drug class. Active gastrointestinal ulcer. Children under 12 years. Precautions: patients instructed to consult their doctor if symptoms persist for more than three days. Patients should seek medical advice if pain or fever worsen, or new symptoms occur. Use Nurofen Advan caution in patients with asthma or a history of asthma. Side effects: the following, although not exhaustive may occur with Nurofen Advance/or ibuprofen. Common (>1%): dizziness, epigastr fatigue, headache, dyspepsia, diarrhoea, nausea, rash. Less common (0.01-1%) allergic reactions (swelling, hives), rhinitis, GI bleeding, peptic ulcer, insomnia, visual disturbances,

CROOKES HEALTHCARE

analgesics to speed?

New Nurofen Advance contains ibuprofen lysine. A number of studies have each shown that ibuprofen lysine gets to work significantly faster than solid dose forms of aspirin,[1] paracetamol[2] and even standard ibuprofen.[3,4]

This makes Nurofen Advance a unique, fast acting analgesic designed specifically for people who specify speed as their priority for analgesic choice.

Nurofen Advance delivers Nurofen's trusted pain relief with the additional benefit of lysine to speed up absorption.[5] So when customers need speed of relief to get on with their lives, recommend Nurofen Advance.

new

aster by Design

s. Rare (<0.1%) oedema, leucopenia, thrombocytopenia, aseptic meningitis (usually in patients with autoimmune disease ons, liver function abnormalities, depression, renal dysfunction. Nurofen Advance like ibuprofen acid may prolong bleeding time le inhibition of platelet aggregation. **Product Licence Number:** PL 13249/0001 **Licence holder:** Johnson & Johnson MSD Pharmaceuticals HP10 9UF **Manufactured by:** Merck Manufacturing division, NE23 9JU **Legal Category:** P **Price:** vance 10's £1.65, 20's £2.89, 40's £5.45 **Date:** November 1997 **References.** 1 Source: Nelson SL, Brahim JS, Kore *et al* 994;**16** 458-465 2 Mehlisch DR, Jasper RD, Brown P *et al* Clin Ther 1995;**17** 852-860 3 Hummel T, Huber H, Kobal G gy Communications 1995;**5** 101-108 4 Cooper SA, Reynolds DC, Gallegos LT *et al* Clin Pharmacol and Ther 1994 d Data on file, Boots Healthcare International 5 Data on file, Boots Healthcare International Report No NU 5003

CHEMIST & DRUGGIST
THE NEWSWEEKLY FOR PHARMACY

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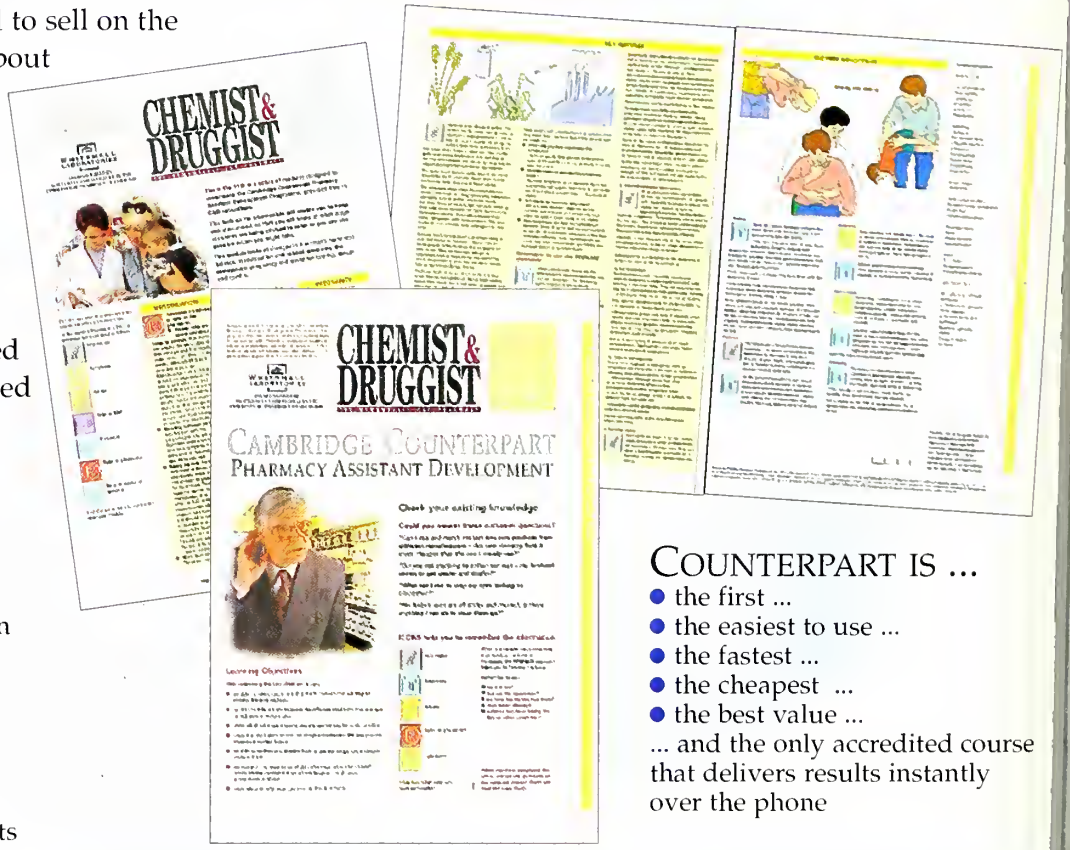


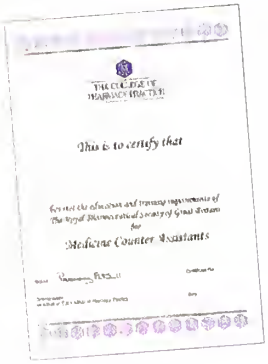
THE WAY IT WORKS

STEP 1 Fill out the registration form to obtain the teaching modules, questionnaires and pharmacist briefings pack for just £17.63 inc VAT (one pack covers up to four assistants).

STEP 2 Register your assistants for instant telephone marking and College of Pharmacy Practice Certificate on completion (£29.38 each inc VAT) on the form.

STEP 3 Follow the stages in the pharmacist briefing and coach the assistants through all modules.

STEP 4 Make sure the multiple choice questionnaire responses are entered over the phone as each module is completed. Give your advice if a second attempt is needed.



STEP 5 A CPP Certificate is automatically available to each of your assistants who successfully completes the course.

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Please list by name the assistants you wish to register for Counterpart. For each individual the cost is £29.38, including VAT

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I subscribe to C&D at the above pharmacy address and need ( ) complete sets of Counterpart modules 1-14 (£17.63 including VAT). £ _____

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Cheques should be made payable to:
Miller Freeman plc and sent to Sue Cheeseman, Pharmacy Special Projects, Chemist & Druggist, Sovereign Way, Tonbridge TN9 1RW

PHARMACY update

How to muscle in on strains and sprains

Soft tissue injury and other strains and sprains are discussed by Derek Balon, community pharmacist and King's College London lecturer

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1086), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* MAY 9, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To be aware of the causes of soft tissue injuries
- To understand the pathophysiology of such injuries
- To recognise drug and non-drug management
- To be aware of the mechanism of bruising
- To be aware of other musculoskeletal injuries

This article concentrates on minor soft tissue, muscular or connective tissue damage which causes pain and is within a community pharmacist's remit. More serious conditions including arthritis, rheumatism and osteoporosis will not be considered.

Stress/soft tissue injury

This condition refers to injury to muscles, tendons and ligaments. Such injuries include sprains and strains. Sprains are stretched or torn ligaments, the damage being either partial or complete rupture of the tissue (ligaments are bundles of parallel connective tissue fibres which form a capsule around some joints). Strains refer to stretched or torn muscle or tendon tissue.

Incidence

The PAGB 1987 survey found that 28 per cent of respondents reported pain from injury/strains/sprains' during the previous twelve months and 9 per cent in the previous two weeks. These findings do not correspond with pharmacy practice in terms of requests for either products or advice.

Causes

Sprains occur when the joint is forced to move beyond its normal range of motion. This includes moving in a plane in which it is not designed to function. Such motion may be rapid (a severe change of direction when running at full speed) or slow (the gradually increased twisting of the ankle joint when skiing). Strains are usually the result of the use of excessive muscular force. This may be exemplified by the force applied to the calf muscle when starting a race from starting blocks. Any sudden change of direction such as slipping (even when walking) may cause this injury. Overuse of a muscle may produce muscular pain which may be the result of strain. Poor (inappropriate) footwear or an uneven walking surface may also be responsible.

Pathophysiology

Sprains and strains are primarily recognised by pain. Pain is a common symptom which different people experience in different ways. It has been defined as an 'unpleasant sensory and emotional experience associated with actual or potential tissue damage'.

Pain is recognised by the brain through specific receptors which respond to pressure, temperature and chemical agents. Tissue damage results in chemical mediators being released (histamine, bradykinin, prostaglandins, 5-HT, proteases) which may either stimulate pain themselves or reduce pain threshold. Ischaemia (lack of oxygen and build up of lactic acid) also induces pain.

One concept which accounts for many of the characteristics of sensory skin/soft tissue pain perception is known as the gate theory of pain. The small unmyelinated 'slow' C fibres carry cold and pain stimuli (eg sprain/strain) to the dorsal horn of the spinal cord. The gate theory suggests that firing the C fibres inhibits G cells in the *substantia gelatinosa*, opening the gate and allowing transmission of pain stimuli through T cells to the brain via the opposite lateral spinothalamic tract. Heat (and other 'sharp' pain) stimuli carried by myelinated 'fast' A fibres excite the G cells which acts as a gate to reduce firing of the T cells and this in turn reduces firing of fibres in

Continued on PII ➤

◀ Continued from PI

spinothalamic tract, thus reducing pain perception. One pain inhibits the other.

It is important to note that the above definition of pain accepts an emotional component and this has practical implications. In a clinical trial, patients who were told their post-operative recovery would involve pain requested fewer analgesics than a control group who had no prior briefing. This indicates that a psychological component altered how patients reacted to pain.

Questions to ask:

- where is the pain?
- how long have you had it?
- can you relate it to a specific event eg running, twisting, lifting?
- is it motion/movement related?
- how do you feel generally?

Diagnosis

Sprains and strains are usually easy to diagnose. The provoking factor almost invariably suggests a working hypothesis. The only complication is if there is more serious damage such as a fracture of the underlying bone. In some cases this can only be established by X-ray. Location often provides a clue to distinguish between a sprain or a strain, but this is not essential as treatment of both conditions is identical. Time for remission differs.

Management

Apart from the very young or old, no risk groups constitute any problem. The very young are rarely affected and unless there is clear evidence of a minor trauma, patients should be referred. Problems with the elderly are related to the slower healing process and whether temporary restriction of movement may cause other problems. For example, an ankle sprain may restrict walking with resultant long-term consequences.

Non-drug management

The initial management strategy relies on RICE (rest, ice, compression, elevation). The terms 'ice' and 'compression' refer to the use of a compress which should cool and restrict blood flow to the area. After the initial treatment, compression may be provided by an elasticised bandage. An elasticised stockinet may not provide sufficient support and even a crepe bandage is not as good as some commercially available alternatives.

Elevation refers to raising the damaged area as high as is possible to reduce hydrostatic pressure.

Massage and heat have a part to play in some soft tissue injuries. Heat stimulates the A fibres as described above. It also helps restore the elastic properties of collagen which gets stretched in sprains and strains. However, if applied during the early stages of the condition, it increases blood supply and hence may increase release of adverse chemical mediators.

Massage acts as a counterirritant. Again, this should not be applied too soon after the injury but light rubbing seems to initiate pain relief by the gate theory mechanism.

Product selection

Drug therapy for sprains and strains can be systemic or topical. Systemic drugs are primarily of two types (which overlap), the minor analgesics and the NSAIDs. Neither require comment in this section as they are well documented elsewhere.

Topical treatment includes local anaesthetics, local NSAIDs and counterirritants.

- **Counterirritants**

Counterirritants (see Table 1) are medications applied to the skin which produce a mild local inflammatory response. Their mode of action is not clearly established, but one theory has already been discussed. An alternative explanation may be that they release and deplete substance P from the sensory nerve endings. The release causes the burning (counterirritant) and local 'flare' effects, and eventually temporarily disables the sensory nerve because there is no more substance P available. Some counterirritants also have a rubefacient effect, that is they produce local vasodilation. The increased blood flow may produce local temperature elevation which is also counterirritant.

Caution must be exercised in interpreting the physiological effect of these drugs since there is a strong psychological component in pain relief. It could well be that the warming effects and the odour associated with many of the preparations used in this manner have an important placebo activity.

- **Topical NSAIDs**

There are conflicting reports as to whether topical NSAIDs are pharmacologically effective or if their activity is related to both the placebo effect and that of massaging the preparation on the skin.

They are believed to exert their action by the same mechanism proposed for their systemic administration. As they are absorbed, the same cautions apply for asthmatics and stomach damage.

- **Local anaesthetics**

These include cold sprays as well as ointments, creams and gels.

In common with all conditions where the medicinal preparation masks pain that is designed by nature to warn us of damage, caution must be exercised by pharmacists when recommending these products. Patients must be informed of the dangers of using damaged tissue, the effects of such movement may be to increase the damage already present.

Box 1: Drugs affecting blood/platelet production or clotting mechanism

warfarin, thiazides, quinine, dipyridamole, steroids, allopurinol, NSAIDs, aspirin, sulphonamides, heparin, penicillin, rifampicin, tricyclic antidepressants

Bruising

This is most commonly a sign of trauma and is characterised by discoloration of the skin. The PAGB 1987 survey found that 46 per cent of respondents reported bruising during the previous 12 months and 12 per cent in the previous two weeks. This is a surprising finding and does not correspond with pharmacy practice in terms of requests for either products or advice.

Pathophysiology

Blood may escape from small blood vessels or capillaries for a variety of reasons, including trauma, and an abnormality of blood clotting mechanism. Abnormalities of the clotting mechanism will not be considered in this article, but it should be noted that disease states (eg meningitis), drugs (eg steroids, warfarin overdose, penicillin), alcohol, Vitamin K deficiency, as well as capillary fragility may be responsible and such patients must be referred.

Purpura is abnormal bleeding into the skin or mucous membranes. If the areas become confluent it results in the typical discoloured signs of bruising. The energy imparted on trauma may rupture blood vessels (a bruise) and/or release chemical substances which increase capillary permeability leading to oedema (local swelling). This local haemorrhage frequently starts off bright red and changes colour with time: dark red/black fading to dark green, light green, yellow and finally disappearing. The colour change is the result of gradual dissolution of the congealed blood by the normal blood enzymes.

Significant points

Unexplained bruising requires careful consideration. If a bruise is the result of mild pressure or there is no recollection of any trauma, the patient must be referred. Senile purpura (old age bruising) refers to spontaneous bruising which commonly occurs on the extensor surfaces on the hand and forearm of the elderly. It is due to increased capillary fragility and degeneration of the supporting elastic tissue. Such patients should be referred to their practitioner for assessment. It is usually not serious and the patient should not be alarmed.

Many drugs affect the blood/platelet production or the clotting mechanism and some are listed in Box 1.

Questions to ask

- can you recall any trauma which could account for the bruise?
- are you taking any medicine? which ones?
- do you have any chronic condition?
- do you have any other symptoms?

Treatment

Assuming that the bruise is a result of trauma, a cold compress should be applied immediately. This reduces the blood supply to the area by vasoconstriction, reducing the localised internal bleeding and slowing the release of the oedematous chemical mediators. The compress should be renewed regularly

Continued on PIV ▶

EVIATED PRESCRIBING INFORMATION
ST fexofenadine hydrochloride
ntations: Telfast 120 is a film-coated peach coloured
t containing fexofenadine base equivalent to 120mg of
enadine hydrochloride. Telfast 180 is a film-coated peach
red tablet containing fexofenadine base equivalent to
g of fexofenadine hydrochloride **Indication:** Telfast 120
nsed for relief of symptoms associated with seasonal
c rhinitis and Telfast 180 is licensed for relief of symptoms
iated with chronic idiopathic urticaria. **Dosage &**
nistration: For the treatment of seasonal allergic rhinitis,
commended dose of fexofenadine hydrochloride for
and children aged 12 years and over is 120mg once
For the treatment of chronic idiopathic urticaria, the
mended dose of fexofenadine hydrochloride for adults
ildren aged 12 years and over is 180mg once daily The
cy and safety of fexofenadine hydrochloride has not
studied in children under 12 years. **Contra-indications:**
hypersensitivity to any of the product's ingredients.
utions: It is not necessary to adjust the dose of fexofenadine hydrochloride in the elderly or in renally or hepatically impaired patients (Although as with most new drugs, fexofenadine hydrochloride should be administered with care in these special risk groups) **Side effects:** In controlled clinical trials the incidence of commonly reported adverse events observed with fexofenadine was similar to that observed with placebo. These adverse events were headache, drowsiness, nausea, dizziness and fatigue. **Pregnancy & Lactation:** As there is no experience with fexofenadine hydrochloride in pregnant women, Telfast 120 and Telfast 180 are not recommended in pregnancy or for mothers breast-feeding their babies **Legal Category:** POM **Package Quantities:** Packs of 30 tablets. **Marketing Authorisation Number: Telfast 120:** PL 4425/0157 **Telfast 180:** PL 4425/0158 **NHS Price:** Telfast 120 Tablets £7.40 Telfast 180 Tablets: £9.63 **Marketing Authorisation Holder:** Marion Merrell Ltd, Broadwater Park, Denham, Uxbridge, Middlesex, UB9 5HP. Further information including a full Summary of Product Characteristics is available from **Hoechst Marion Roussel Ltd** at the above address.

Date of Preparation: February 1998.

Telfast 120®
fexofenadine 120mg o.d.

Hoechst Marion Roussel

Hoechst

Hoechst Marion Roussel
The Pharmaceutical Company of Hoechst

Table 1: Drugs that have counterirritant effects

methyl salicylate and other salicylates	menthol
camphor	methyl nicotinate
turpentine	capicum

◀ *Continued from PII*

to keep it cold and it may be left in place for up to two hours. If the bruise is severe, compression and elevation may be useful. The area should not be massaged or heat treated in the early stages.

Heparinoid and hyaluronidase containing topical applications may help to disperse the congealed blood and oedema, and so reduce swelling.

Related conditions

- **Repetitive strain injury**

Repeated overuse of muscles and tendons produce pain, fatigue and reduced efficiency of that limb. Sufferers should stop doing what causes the pain. Treatment includes rest of the limb, massage and analgesics, both systemic and topical. Alternative treatment includes acupuncture and osteopathy. All patients should be referred.

- **Bursitis/synovitis/tendonitis**

These conditions refer to inflammation of the bursae (tissues around joint and where bones are contiguous), synovial capsule and tendons. They are characterised by localised swelling, erythema and pain. Treatment consists of rest, analgesics and anti-inflammatory agents. In extreme cases, corticosteroids, both by local injection and systemically, aspiration and surgery may be required. Such patients should be referred.

- **Frozen shoulder**

This refers to local shoulder pain and restricted movement and causes may include occupational strain, arthritis, synovitis, bursitis and tendinitis. Treatment is similar to bursitis. Again all patients should be referred.

- **Back pain**

Caution should be exercised by pharmacists in managing such patients since the symptoms may be due to a serious condition. If the pain emanates from the kidneys or there is 'pins and needles' and numbness (paraesthesis), the patient must be referred.

A pharmacist considering managing the patient should first think about:

- the patient's age
- the possibility of organic disease
- whether height, weight, work or recreational activities are related to the problem
- provoking factors which can be identified
- is the patient pregnant?

Serious conditions which may present backache symptoms include:

- rheumatism and arthritis
- ankylosing spondylitis
- disc prolapse
- spinal root compression
- spinal defect
- osteoporosis
- bone cancer
- mechanical trauma
- physical stress injury

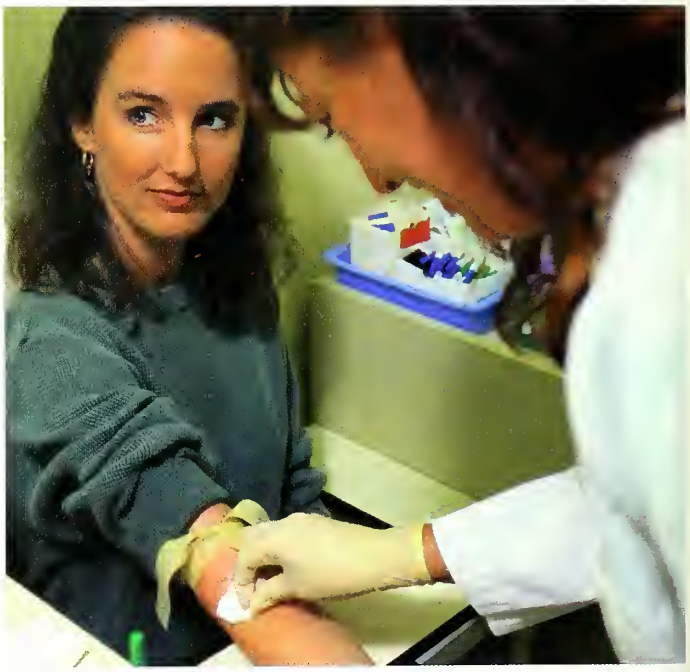
C&D is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2000.

ACTION PLAN

1 For the next 20 cases of bruising you see, record in your practice workbook their cause, the age of the patient and any drugs they are taking where possible. Can you identify any spontaneous bruising cases? Is it related to age? Or a drug?
2 Record in a table the next 20 cases of sprains and strains. Differentiate between them and record their causes.
3 Record in your practice workbook the products you stock to treat sprains and strains. For each type of product, select the ones you favour, noting your reasons. Discuss these with your staff.

Let it flow in practice

In this second article on anticoagulants, principal pharmacist Jo Martindale, who runs the anticoagulant clinic at the West Middlesex University Hospital, explains some of the practical issues of running a clinic in the community



As more traditionally secondary care treatment is now being undertaken in the community sector, it is important that primary health care professionals, including community pharmacists, understand the treatments concerned, and are capable of managing them.

Anticoagulant monitoring is an ideal example of how primary and secondary care can work together. Most anticoagulant patients are still initiated in the hospital setting, but their long-term management could be undertaken in the primary sector with the more complicated patients still being managed within the hospital where necessary.

This should be more acceptable to patients as travelling is usually easier, and it avoids waiting in busy hospital clinics.

Some GP practices are already involved in anticoagulant monitoring, whereas for others it would be a new experience, and many feel they do not have the resources to run such a service. Therefore, this is an ideal time for more community pharmacists to extend their role into this field. The advantages of doing this are listed in Table 1.

Clinic function

All patients receiving anticoagulation require regular monitoring. For most patients this means INR testing for their warfarin.

When patients are initially

Continued on PVI ▶

PHARMACYupdate: distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of **Genus Pharmaceuticals**, C&D's readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the May 9 issue, which will cover this week's CPP-accredited modules, together with those in the April 18 issue.

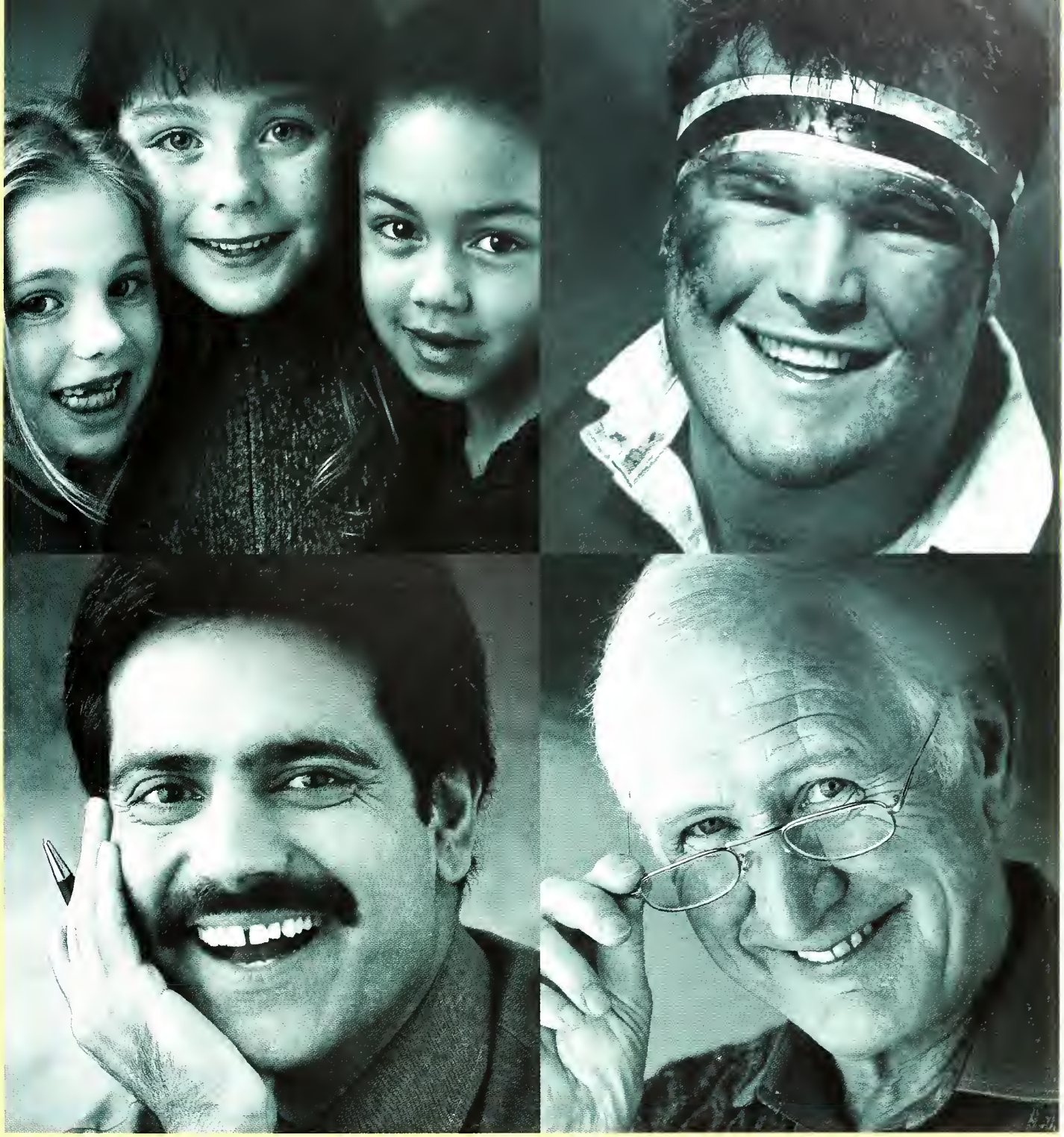
The MCQ paper for the April modules will be enclosed in next week's C&D covering:

- Thrush (1083)
- Aromatherapy (1084)
- LCP function (1085).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

C&D in association with

GENUS PHARMACEUTICALS



Classification and Diagnosis

Written by Terry McGuire

in association with

CHEMIST & DRUGGIST

mannheim boehringer

Better Management in Diabetes Care

Learning Objectives

- *To understand the nature of Diabetes Mellitus*
- *To embrace the goals of diabetic management*
- *To be aware of the pharmacists' role in testing for the disease*
- *To know the classification of Diabetes Mellitus*

Classification and Diagnosis

In both types of diabetes, NIDDM and IDDM, the main aim is to control blood glucose to avoid long-term large and small vessel disease. The central issue facing those concerned with diabetic care is whether these various complications are an inevitable part of the diabetic syndrome. Recent evidence from a large international study suggests that abnormally high blood glucose concentrations in poorly controlled IDDM patients are a major factor causing small blood vessel disease, possibly by altering the structure and function of the basement membrane of capillaries. It is now increasingly apparent that nothing concerning diabetes mellitus can be expressed in such simple terms, so altered lipids, abnormal platelet behaviour and fibrin deposition are other factors to contend with as well as raised blood sugar concentrations. Diabetes mellitus is not a single entity but a panorama of disorders with hyperglycaemia as a common factor, yet current evidence suggests that strict control of blood glucose, within the normal range (4.00-8.00 mmol/L for IDDM patients and 4.00-9.00 mmol/L for NIDDM) will significantly reduce the impact of the disease.

Desirable goals of diabetic management are:

1) The ability of the diabetic patient to have a satisfactory quality of life and to carry out normal activities such as employment.

2) Freedom from episodes of diabetic ketoacidosis and hypoglycaemic reactions.

3) Achievement of the ideal body weight for the patient's sex, age and height.

4) Maintenance of normal blood glucose with no glycosuria.

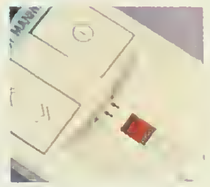
Testing

Clinical tests for the detection and monitoring of blood glucose have been available for many years. Pharmacists have traditionally supplied testing kits, both on prescription and on sale OTC but, as a rule, they have not been involved in performing the tests. The simplicity of diagnostic tests allows them to be performed in the doctor's surgery during a consultation and diabetic patients are trained to perform the tests at home. Indeed the nature of the disease, with variation in blood glucose occurring during the day, would suggest that the patient is the most suitable person to monitor their condition.

Approximately two percent of the UK population suffers from diabetes mellitus. Regrettably many diabetic patients, mostly those with non-insulin dependent diabetes mellitus (NIDDM), remain undetected as the disease often lacks any clear symptoms. However, it still has the potential to create physiological changes that can result in long-term complications such as coronary heart disease, eye damage, vascular complications and kidney disease. It has been estimated that in the UK for each case of diagnosed NIDDM there is likely to be one patient with undiagnosed disease, making a possible 500,000 undiagnosed cases. In addition, a large percentage of diabetic patients fail to manage their disease appropriately, which may be due to their inability to perform home blood glucose tests properly or from their lack of knowledge about the disease and how to reduce its long-term complications.

The pharmacist, the only member of the primary health team who has daily contact with large numbers of healthy people and who supplies diabetic patients with medication, needles, syringes and testing kits, would appear to be ideally situated to:

- *Identify undetected diabetic patients through the provision of a testing service for non-diabetic clients.*
- *Advise on the use of testing kits and the significance of results for diabetic patients.*
- *Provide test results for patients who have difficulty performing tests or as a service for GP surgeries in the locality.*
- *Advise diabetic patients on adopting a healthy lifestyle to avoid long-term complications.*

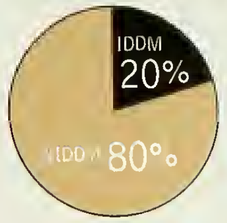


Classification of Diabetes Mellitus

Diabetic patients are classified into "Insulin-Dependent Diabetes Mellitus" (IDDM), and "Non-Insulin-Dependent Diabetes Mellitus" (NIDDM) and these, more descriptive and informative terms have replaced the old terms of "juvenile onset" (Type 1) and "maturity onset" (Type 2) diabetes. Genetic, immunological and hormonal factors appear to explain to some extent the subtle difference between IDDM and NIDDM. However, in both types of diabetes, some environmental factor triggers diabetes in a constitutionally and probably genetically susceptible person.

IDDM

Approximately 20% of the diabetic population has this form of the disease. These patients have little or no pancreatic insulin, have a tendency to develop ketoacidosis and must inject insulin to sustain life. The genetic basis of IDDM has been greatly clarified by discoveries in the human histocompatibility antigen field (HLA). People with certain HLA types have an increased frequency of developing diabetes. Viral infections appear to be the most probable agent linking the genetic susceptibility with damage to the pancreas possibly by way of an autoimmune process. This form of the disease often occurs in patients before the age of thirty with a peak occurrence around the age of 10-14 years. After the initial diagnosis of IDDM some patients can experience a remission of the condition for a few months, the "honeymoon", but will eventually need daily injections of insulin.



Percentage
of Diabetic population

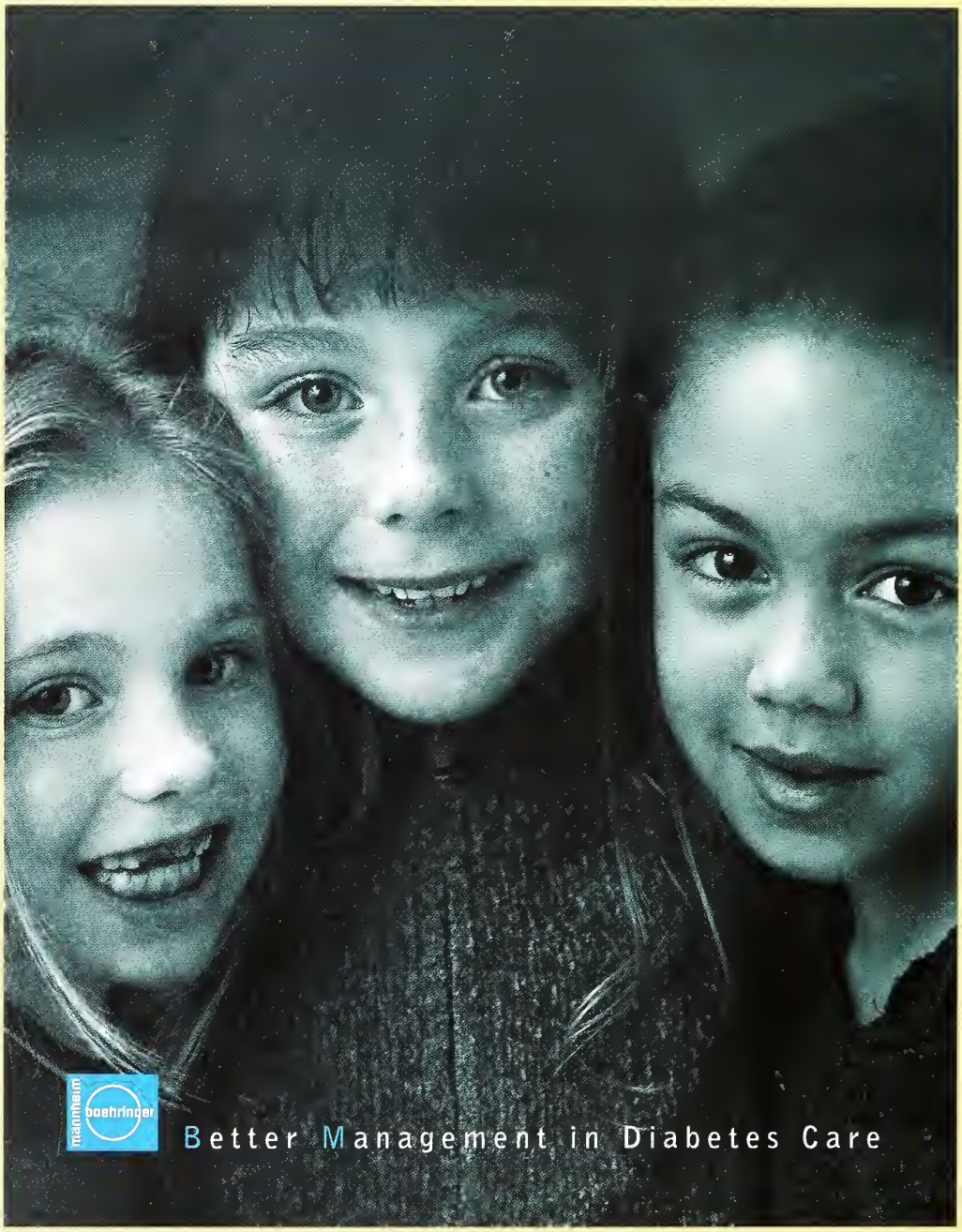
NIDDM

Individuals with this type of diabetes comprise approximately 80% of the diabetic population. These patients retain some pancreatic reserve and can be treated with diet, exercise and drugs (sulphonylureas and biguanides). Nevertheless a considerable number may eventually require insulin. The onset of NIDDM is gradual. Because they have sufficient serum insulin concentration to prevent the breakdown of fat they generally have no history of ketoacidosis. Obesity is a major factor in unmasking the disease.

NIDDM patients can have a combination of metabolic defects. They can suffer from an impairment in the secretion of insulin, their tissues, eg. muscle and liver, may exhibit decreased responsiveness to insulin due to decreased numbers of insulin receptors or altered binding, and patients may have an elevated hepatic glucose output.

Diagnosis of Diabetes Mellitus

Diabetes mellitus has been known from the beginning of medical history yet the pathology of the disease remains unclear in many respects. Diabetes is more correctly viewed as a description of symptoms rather than a diagnosis. It describes a group of diseases characterised by chronically elevated blood glucose concentration often accompanied by other clinical and biochemical abnormalities. The disease may vary in its expression from totally asymptomatic to rapidly fatal.



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Detrusitol™▼ Abbreviated Prescribing Information. **Presentation:** *2 mg tablet*: white, round, biconvex, filmcoated tablet (engraved with arcs above and below the letters DT) containing tolterodine L-tartrate corresponding to 1.37 mg tolterodine. *1 mg tablet*: white, round, biconvex, filmcoated tablet (engraved with arcs above and below the letters TO) containing tolterodine L-tartrate corresponding to 1 mg tolterodine. **Indication:** For the treatment of unstable bladder with symptoms of urgency, frequency or urge incontinence. **Dosage: Adults:** 2 mg bd except in patients with impaired liver function where 1 mg bd is recommended. The dose may be reduced to 1 mg bd if side-effects are troublesome. Review after 6 months. **Children:** Not recommended. **Contraindications:** Patients with urinary retention, uncontrolled narrow angle glaucoma, myasthenia gravis, known hypersensitivity to tolterodine or excipients, severe ulcerative colitis or toxic megacolon. **Precautions & interactions:** Use with caution in patients with significant bladder outlet obstruction at risk of urinary retention, gastrointestinal obstructive disorders, renal disease, hepatic disease (see dosage), autonomic neuropathy or hiatus hernia. Organic reasons for urge and frequency should be considered before treatment. Concomitant treatment with potent CYP3A4 inhibitors, such as macrolide antibiotics (e.g. erythromycin) or antifungal agents (e.g. ketoconazole) should be avoided until further data are available. The ability to drive and use machines may be affected by visual accommodation disturbances. A more pronounced therapeutic effect and side-effects may be seen if used with other medicinals that possess anticholinergic properties. Muscarinic cholinergic receptor agonists may reduce the effect of tolterodine, whereas tolterodine may reduce the effect of metoclopramide and cisapride. Pharmacokinetic interactions are possible with other drugs metabolised by or inhibiting cytochrome P450 2D6 (CYP2D6), or CYP3A4. No interactions seen with warfarin or combined oral contraceptives (ethinyl estradiol/levonorgestrol). No clinically significant interaction with fluoxetine. **Pregnancy & lactation:** Until more information is available tolterodine should not be used during pregnancy or lactation. Women of fertile age should be using adequate contraception. **Side-effects:** Those reported include: *common (>1/100)* dry mouth, dyspepsia, constipation, abdominal pain, flatulence, vomiting, headache, xerophthalmia, dry skin, somnolence, nervousness and paresthesia; *less common (<1/100)* accommodation disturbance and chest pain; *uncommon (1/1000)* allergic reactions, urinary retention and confusion. **Overdose:** In the event of tolterodine overdose, treat with gastric lavage and give activated charcoal. Treat symptomatically. **Legal category:** POM **Pack sizes:** Detrusitol 2 mg and 1 mg in cartons of 56 containing 4 blister strips of 14 tablets each. **N.H.S. Price:** Detrusitol 2 mg (56) £32.00, Detrusitol 1 mg (56) £28.80. **Marketing Authorisation numbers:** Detrusitol 2 mg tablets PL 0032/0223, Detrusitol 1 mg tablets PL 0032/0222 **Marketing Authorisation Holder:** Pharmacia & Upjohn Limited, Davy Avenue, Milton Keynes MK5 8PH, UK **Date of Preparation:** February 1998.

References: 1. Nilvebrant L et al. Eur J Pharmacol 1997; 327:195-207. 2. Malone-Lee JG et al. 27th Annual Meeting of the International Continence Society (ICS), 1997, Yokohama, Japan (Study 012). 3. Abrams P et al. 92nd Annual Meeting of the American Urological Association (AUA), 1997, New Orleans, USA (Study 008).

◀ Continued from PIV

stabilised in hospital, they are closely monitored. However, once they are discharged and start to rehabilitate, they will resume their normal lifestyle, diet and the everyday stresses of life. All these factors can affect a patient's warfarin control, so it is important that monitoring continues.

Hospital setting

Most hospitals have some kind of outpatient management system for anticoagulant patients. These can vary significantly, depending on who runs them and how they are managed.

Who runs them

- haematologist
- hospital pharmacists
- laboratory staff
- special nurses.

Clinic management

- each individual patient is seen by the clinic staff
- books are posted to the patient so that they don't have to wait for their results. Clinic staff are available if patients wish to see them.

There are advantages and disadvantages to both these methods. The first is very time-consuming, but it means that any changes in INR can be discussed with the patient in the clinic. It also means that the patient knows the result and dosage straight away.

If the patient has already left the clinic, any dosage changes are posted to them in their yellow anticoagulant book which may lead to one or two days' delay. If a patient is found to have a high INR, they will need to be contacted by phone to discuss any potential causes and symptoms, for example. However, this method does mean more patients can be monitored in the clinic, and most patients who are stable do not have to wait unnecessarily.

In some hospitals, there is no formalised anticoagulant clinic and patients are monitored by the consultant team who initiated therapy.

Community setting

As previously mentioned, there is a great potential for moving anticoagulant services into the community. How this is undertaken will depend on a number of factors including:

- demographics of the area
- size of local GP practices
- integration of community pharmacy within the primary care multidisciplinary team
- opinion of local medical committee
- Health Authority priorities.

To discuss the potential ways to run a primary care anticoagulation clinic in detail is beyond the scope of this article. Therefore, the main principles will be discussed and illustrated assuming a clinic is being set up within a Health Centre and involving GPs and a community pharmacist. However, the same principles could apply to all scenarios.

In some hospitals, there is no formalised anticoagulant clinic

Table 1: Advantages of community pharmacist-managed anticoagulant clinics

In-depth knowledge of mechanism of action, interactions and side effects of anticoagulants
Access to records of all dispensed medicines
Can advise on OTC purchases
Possess necessary management skills
Experienced in writing and following protocols
Convenience for patients
Good links with local GP practices
Increases profile of pharmacy with other health care professionals and the public
Improves communication with local hospitals

Principles of service

The principles of setting up a community anticoagulant service are outlined below (a summary is shown in Figure 1).

1. Identify patient cohort

Before any plans can be made to set up a clinic, it is important to know how many patients will be involved. This information should be available from the practice records for warfarin prescriptions. Alternatively, the hospital clinic should have GP information on all its patients. If possible, patients should be asked about their preferences. Although it will not be possible to satisfy all their requirements, some could be incorporated into the service.

2. Identify necessary resources and funding

Setting up a clinic from scratch can be both time-consuming and expensive. It is imperative that all resources needed (including personnel, patient management system, space, equipment and overheads) are identified. A mistake here could jeopardise the future of the clinic.

Therefore, a rough outline of how the clinic will run should be made and from this, a business case prepared summarising the resources and potential funding that will be necessary. The community pharmacist will also need to take into account expenses such as locum fees – to cover for absence – when calculating necessary resources.

How the funding is obtained will depend on the GP practice, its fundholding status, the Health Authority and the local hospitals. If the practice is fundholding then it will currently be paying the hospital for monitoring these patients and this amount must be identified. Non-fundholders will need to access resources through the Health Authority who will have contracts with the local hospitals.

The ease of identifying this money will depend on how the anticoagulant services are included in the hospital contracts. Usually the anticoagulant service is identified separately, but if it is included within the outpatient numbers it may be more difficult to calculate exact costs.

The Health Authority may also have additional money available to encourage such schemes which would assist in setting the clinic up.

3. Liaise with local hospitals

It is advisable to contact the hospital anticoagulant clinic as it is a great source of information and will be providing discharge information on the patients. It may also be able to provide advice regarding setting up the clinic and necessary protocols, for example. It would be prudent at this stage to visit the hospital clinic to gain both an understanding of the processes involved and ideas on how best to develop the clinic.

4. Training of staff

All staff involved in the clinic management will require adequate training. The pharmacist running the clinic will need to be clinically up-to-date on all aspects of anticoagulation. A formalised training programme should be arranged which may also need to be funded. Training can be obtained from various sources such as the hospital anticoagulant clinic, the hospital pharmacy (as it is often involved with inpatient monitoring and counselling of patients), or existing primary care anticoagulant services. The Health Authority may also have training resources available.

Continued on PVIII ▶

Valproate - the case for brand prescribing

Clinical experience shows that switching to different manufacturer's versions of sodium valproate may lead to significant toxicity or loss of seizure control in some people with epilepsy[1]. The implications for these patients are enormous, affecting their quality of life, work and mobility. Many GPs now believe that there is a strong case for prescribing valproate by brand[2], and community pharmacists are ideally placed to intervene to encourage safe prescribing.

A recent study in York[3] produced evidence against generic prescribing for epilepsy. A proportion of patients experienced seizures and side-effects when they changed to a different manufacturer's version of sodium valproate, phenytoin and carbamazepine. The researchers suggested that the small amount of money saved by generic prescribing was outweighed by "negative health gain" for the patient, increased work in general practice and increased social costs in terms of sick leave and loss of employment.

Since then, doctors are increasingly accepting that patients should keep to the brand on which they have been stabilised in the hospital clinic[2]. Some hospital pharmacies are particularly concerned that patients discharged on anti-convulsants obtain a consistent supply of their medication in primary care. They have taken the initiative to ensure seamless care and are labelling take-home medication with both the brand and generic names. The aim is to alert the GP, patient and community pharmacist to the make of the tablets dispensed and the majority of hospital contracts for sodium valproate are now for Epilim. In order to reinforce the message, they are also producing patient information leaflets highlighting the importance of consistent supply, which are given to patients upon discharge. The growing number of pharmacists working in GPs surgeries also have a vital educational and communication role to play with GPs, nurses and patients.

As Epilim comes under category D of the Drug Tariff, community pharmacists are paid for dispensing it against a generic prescription provided the prescription is endorsed with the manufacturer's name and the pack size.

MIMS recommends that all anti-convulsants are prescribed by brand name as "there is a loss of seizure control when a patient's medication is switched between different manufacturer's versions of the same anti-convulsant" and that prescribers should ensure that "patients are not transferred from one preparation to another without full clinical assessment and retitration."[4]

Indeed, the Audit Commission which generally supports generic prescribing, stated that "Occasionally there can be sound reasons for keeping to one brand. In particular, slight differences in bioavailability...could destabilise the treatment of epilepsy...In such cases, it is best to specify brands from a single manufacturer ...Variations in colour or appearance might confuse some patients."[5]

One chain dispensing Epilim on generic prescriptions is Moss Chemists. Their Professional Services Executive, Rob Darracott says "Moss Chemists support generic prescribing in the NHS as a means of controlling the growth in the drugs bill but as pharmacists we take seriously research suggesting that for some patients, including those taking anti-convulsants, there may be sound reasons for keeping a consistent supply of one brand.

Altered appearance of medicines can confuse patients

Concerns about the bioavailability of generic anti-convulsant formulations provides us with a reason to use Epilim. Offering Epilim when sodium valproate is prescribed, we believe, gives patients a greater degree of confidence in their medicines. It also allows our pharmacists to supply the same product each time in the knowledge that this consistency can improve patient compliance.

We know from our research that, in some therapeutic areas, customers taking regular medication prefer brands and this can be an important contributory factor in motivating them to use medicines effectively. For this reason, it is important that they get them."

References

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The threat of medicine substitution – the patient's viewpoint
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2 Meditex survey
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Seizure 1996;5:1-5

4 Haymarket Publishing Services
Anticonvulsants
Monthly Index of Medical Supplies 1998,March:125

5 Audit Commission
A Prescription for Improvement
London HMSO 1994 p 33

Epilim Oral Prescribing Information

Presentation

Indications

Dosage and administration

Contraindications Warnings etc Contraindications

Side effects

Drug interactions

Pregnancy

Legal category

Further information

Product Licence Numbers

Address

◀ *Continued from PVI*

If a near-patient testing system is to be used, adequate training in its use must also be obtained.

5. Design of clinic

At this stage, the practicalities of running the clinic must be decided. All staff involved in the clinic should be included. The following areas should be addressed:

- location of clinic
- times of clinic/number of clinics per week
- method of INR testing ie sending blood to laboratory vs near-patient testing
- notification of patients
- prescription writing
- recording of information.

6. Writing protocols

Once adequate training is received, protocols for all aspects of the clinic must be written. These are necessary for the anticoagulant clinic to run both safely and efficiently. Examples of necessary protocols are provided in Table 2, although this is not an exhaustive list.

If a computer patient management system (PMS) is to be used for controlling patients, it will have to be programmed for the correct dosing regimes and recall procedures. Comprehensive protocols must be written for its use.

It is advisable to use similar dosing guidelines to those used in the hospital. These are normally based on published data and will ensure continuity of care for the patient.

The British Society for Haematology has written guidelines for the recall of patients to the anticoagulant clinic. Some hospital clinics have adapted these slightly.

Example guidelines are shown in Table 3.

Standards for monitoring should also be produced. These will define the minimum standards necessary and ensure a consistent service is provided. They should cover areas such as:

- premises
- quality assurance
- documentation
- infection control
- training
- dosing and follow up appointments.

Other necessary paperwork includes referral forms, patient information regarding the clinic and standard letters.

7. Audit the service

As with any new service, there will always be small areas that have been overlooked or that could be improved. By regularly auditing the service it is possible to identify these and amend the protocols.

Once the service is up and running a full audit should be performed ideally at three months, but no later than six months. From then on, six to 12 monthly audits should be performed. If there are neighbouring clinics, a system of peer review could act both as a training exercise and improve links for future developments.

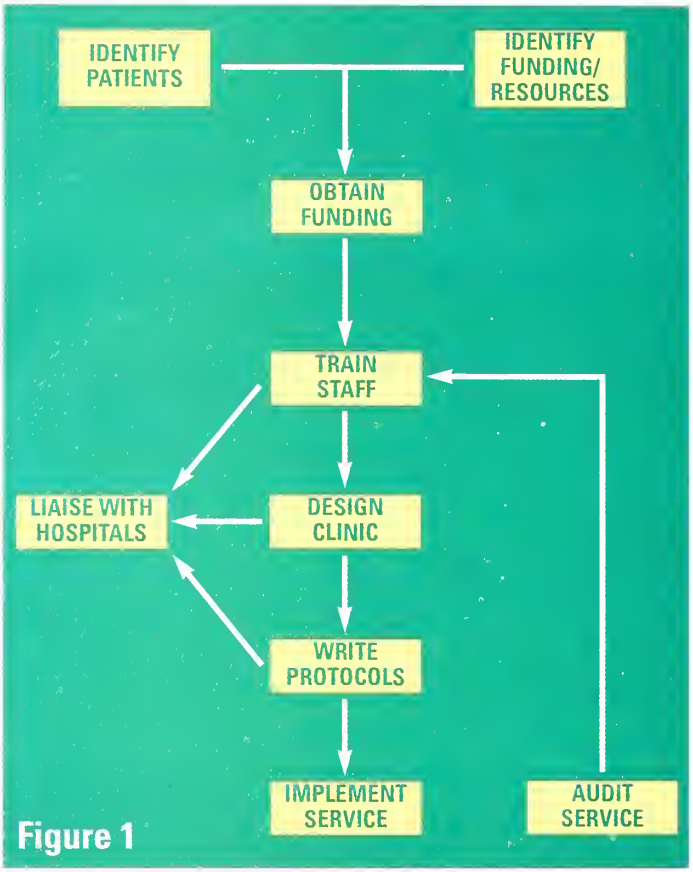

Figure 1

How to get started

The first step for anyone interested in starting an anticoagulant clinic is to do some research. It is important to understand the workload and commitment involved and the resources and support that will be necessary.

Also, find out what the current anticoagulant arrangements are in your area. There is no point in spending valuable time investigating the feasibility of a clinic if the majority of local GPs already manage their own service.

Contact other community-based anticoagulant clinics to find out how they were set up and what mistakes were made. Also find out what funding is available from the Health Authority and other sources. The Health Authority Pharmaceutical Advisor should be able to provide some background information on this and some useful contact numbers.

Patient medication records can be used to identify the patients currently on warfarin and the GPs who would benefit most from a clinic. Approach the GPs concerned with a realistic plan including cost, goals and functions of the service. Once you have the support of the GPs you can start the process above.

Pharmacists should also ensure they have adequate indemnity insurance.

Conclusion

With the publishing of the NHS reforms, and the proposal for multidisciplinary primary care groups, now is an opportune time for community pharmacists to strengthen links with GPs.

Many HAs are keen to move anticoagulant services out into the primary sector. There is money available to GPs for taking on the extra commitment. However, many do not have the resources or time. As the GP's role becomes more diverse, they will be looking to other health care professionals to help develop such services. This is an ideal opportunity for community pharmacists to expand their role and become key members of the primary care team. It would also provide a valuable link between primary and secondary care teams.

As pharmacists, we have the necessary clinical and managerial skills to be able to undertake this responsibility and should use this as a chance to demonstrate our willingness to adapt to changing health care.

Table 2: Protocols for running an anticoagulant clinic

a) Setting up the clinic	selection of patients
	dosage regimes to be used
	target INRs
	use of near-patient testing equipment (if applicable)
	patient records
	entering records onto PMS (if applicable)
	training requirements of staff
b) Running the clinic	referral of patients to clinic
	patient counselling
	initiation of therapy
	dosage adjustments
	appointment intervals
	out-of-range INRs
	referral to specialist
	patients not suitable for primary care management
	patients requiring surgery/dental treatment
	domiciliary visits (if applicable)
	management of standard letters
	stopping treatment

Table 3: Guidelines for the scheduling of return visits to the anticoagulant clinic

Result	*Recall*	*Maximum*
One low INR value	Recall in 7/14 days	2 weeks
One normal INR value	Recall in 28 days	4 weeks
Two normal INR values	Recall in 42 days	6 weeks
Three normal INR values	Recall 56 days	8 weeks
Four normal INR values	Recall in 70 days	10 weeks
Five (or more) normal INR values	Recall in 84 days	12 weeks
One high INR	6-14 days	2 weeks
INR value > 5	Refer to haematologists	

(All patients should be seen at least every 12 weeks)

Words of wisdom

I wonder how many of your readers took the time to study the article by a 'senior industry manager' which appeared in *C&D* March 21, p7.

I have no idea who the author is, but how succinct his observations. I am sure there are many proprietors out there who spend precious hours in the day, or even at home at night, studying price lists to save a few pence. One has to make considerable savings to cover the cost of one hour of a pharmacist's time.

Similarly, they will make decisions to change their wholesaler for a derisory increase in settlement discount, without considering the true cost of such action. Service, trust, stock levels and customer satisfaction must be paramount in any long-term business relationship.

Pharmacists considering change of any supplier should look carefully at any contractual agreement that is built in, as well as the small print and the hidden extras.

Ian Crimp
Marketing/sales manager, Graham Tatford & Co Ltd

Restaurant rage

To state that I am incredulous at the attitude of **Xrayser** (*C&D* March 21) with his comments on the Pharmacy Restaurant is to understate the case.

Xrayser is probably the most widely read column in *C&D*, is significantly influential and taken by many to give the consensus and common-sense view of independent pharmacists. On this occasion **Xrayser** has got it significantly wrong. He has missed the most important point in the argument surrounding protection of the title 'Pharmacy' which is restricted under the Medicines Act 1968. To make light of its highjacking by this celebrity restaurant while not thinking the problem through, does **Xrayser** no credit.

The problem is not with the application of the title to any one restaurant. The problem is that in not prosecuting this illegal use of the restricted title, we may find it used next by a drug store. Having not prosecuted in the first instance, the Society will then not stand on firm ground in prosecuting further infringements. The damage to the title from its use by drug stores must be taken seriously by the RPSGB and by **Xrayser**, even if use by a restaurant is not.

This is not the first infringement of the restricted title. It is, however, the first infringement that has not been stopped by threat of, or use of, legal action. If resolute action is not taken now, then the restriction of the title 'Pharmacy' to those professionals with appropriate training and ethical obligations will be lost.

The Law Department of the RPSGB is assiduous in bringing action against pharmacists for alleged infraction. Pharmacists are put to long periods of aggravation and not insignificant costs often before being notified that their position has been vindicated and no action is required. The Law Department does not even apologise in such cases, yet in this most serious infraction by a non-pharmacy outlet it will not act. Why are restaurateurs treated with fear and pharmacists with contempt?

If the present Council of the RPSGB will not act to defend pharmacy then maybe pharmacists should look to electing a Council with guts.

Ivor Deitsch
Chairman, Kensington, Chelsea & Westminster LPC

A dispensing error

Have you seen this Tesco health care leaflet? It has a dispensing error, a whopper! On p2 at the bottom left there is a tablet bottle carrying a pharmacy label that reads '21 Amoxycillin capsules'. The tablets in the bottle are the same as those out on display. Is it ferrous sulphate?

Aruna Parikh
Wallington, Surrey

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medicine to en
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Scrambling the pharmacy omelette

How well will pharmacy contractors fare in securing resources when competing against the nursing and medical professions? Hemant Patel looks at some of the issues this question raises

More home visits by pharmacists could be on the primary care agenda

The subject needs to be examined against a backdrop of a decline in real income from NHS dispensing and a major initiative to introduce managed care into the UK.

Not only does the recent White Paper – heralding a 'modern and dependable' NHS – need to be looked at; others which have preceded it do as well. There are major implications for community and hospital pharmacy services in a number of key areas. The lack of debate in the profession is extremely worrying.

The government is putting an additional £1.5 billion into the health service this year and next. A further £1bn from cutting red tape will go towards better integration of the health and social services. These funds are marked for general health services rather than medical, nursing or other budgets.

The White Paper claims that the changes will be evolutionary. The timetable issued with the Health Services Circular (HSC 1998/021) shows that change is already underway. Beneath the benign and positive style of the White Paper, and the recent Green Paper – 'Our Healthier Nation' – lies radical intent.

What strategy should pharmacy contractors employ to secure funding for future service developments?

The government is intent on rejecting the notion that growing public expectations, medical advances and demographic changes will overwhelm the NHS. It believes that by using new technology and breaking down professional boundaries, it can meet patients' needs without moving to a charge-based service or radically restricting patient care.

Improving services

A new statutory duty of partnership, between health and local authorities, will ensure co-operation in taking forward national and local agendas for care, designed to improve accessibility and quality of services.

On top of the £2.5bn earmarked to set up primary care groups, there are new allocation criteria for R&D funds in primary care. There will be a single unified budget for all hospital and community services. How will this impact on prescribing costs, script numbers and pharmacy practice?

Already, we are seeing some fundholders and community care providers bypassing community pharmacy by directly supplying dressings, enteral feeds, incontinence and colostomy appliances, as well as vaccines. What other products are likely to follow?

HAs will adopt a more strategic role. They will identify and assess local health needs and monitor health improvement programmes (HIPs) which will involve NHS trusts, PCGs and other primary care professionals

Meeting needs?

The linked health and social care needs of the population will be assessed with a view to developing services to meet identified needs. Who will measure the pharmaceutical needs of the local population? Do we even have a definition?

Primary care groups will plan HIPs in 1998 and put them into action by April 1999. PCGs will be accountable to their health authority and will serve natural communities of around 100,000 people. Nursing and social services will be represented on the governing body.

Although PCGs will have replaced fundholders by April 1999, it will be some time before trust status is granted to aspiring PCGs.

Primary care trusts (PCTs) will be established as freestanding bodies accountable to HAs for commissioning care. They will

Co-operation not competition

The Thames Region Group of LPCs held a conference last Sunday to look at the role of pharmacy in the new NHS

Pharmacists should be giving health authorities and the new primary care groups pharmaceutical advice, said Royal Pharmaceutical Society vice-president Christine Glover (right).

With the size of the drugs bill, pharmacists are the best people as "[they] have more business skills than the rest of the NHS put together".

Mrs Glover urged all local pharmaceutical committees to draw up a short list of pharmacists who would be best qualified to give input to the new HAs. The list should be sent to the director of primary care, she said, emphasising that this should be done quickly. "If you don't put a name forward there's no way that you will get involved," she warned.

Pharmaceutical development groups need to be established in each HA. They should include representatives of the LPC, the local Society Branch, the hospital pharmacy service, and contacts on the HA or Health Board, such as the pharmaceutical advisor. "How this is put together doesn't matter. You have to overcome a reluctance to talk to each other and get on with it," said Mrs Glover. "The way ahead is co-operation, not competition."

All the members of this team should send the same message to the HA, as it will give a better result. In addition, this message can be strengthened by linking with the corresponding medical development group to find out the common agenda.

The development groups should make sure that the PCG and PCT chairmen are informed about pharmacy and are given the list of pharmacists who could be consulted or co-opted. The director of public health's priorities should also be established to find out what the local issues are. The pharmacy drive can then be focused to fit the local agenda.

With community pharmacists' huge investment in premises, equipment and medicines, pharmacy is not just a player but a stakeholder in the NHS. Stressing that action is needed, Mrs Glover warned: "You must be concerned. You have to see the next six months as a milestone or you can forget being in the NHS. If you don't get your feet under the table, you will be left out."

In Scotland the health minister is keen to appoint chairmen and have the PCT up and running, she said. "That's why it is urgent to get things going."

Mrs Glover also believes that the remuneration structure needs changing. "The government hasn't got an alternative at the moment," she said.

If pharmacists cannot demonstrate the value they bring to dispensing, the government may get nurses to dispense.

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Seton Healthcare Group plc

have added responsibility for the provision of community services.

PCTs will be established on the basis that they will have financial, personnel and managerial freedom. I believe their financial freedom, in practical terms, will be shackled by traditional public sector rules.

Their management freedoms could be more significant, since they will be self-governing institutions. This could liberate managers and health care professionals to make much needed improvements to service provision.

Although these freedoms will exist, the issues of probity, accountability and ministerial responsibility will limit the powers of the PCTs. So what are the benefits of such arrangements?

In common with all NHS trusts, PCTs are likely to have the freedom to:

- acquire, own and dispose of assets (eg GP surgeries)
- make cases for capital developments (eg health centres, screening services)
- create their own management structure
- employ their own staff, and set their own terms and conditions of employment
- generate income without interfering with other obligations (perhaps by owning pharmacies?).

National Service Frameworks and guidelines issued by the new National Institute for Clinical Excellence (NICE) will help ensure local consistency and develop an evidence-based service. The Commission for Health Improvement will intervene where the variation in services or finance is outside acceptable limits.

With capped budgets and rising costs, there will be a need to manage allocated budgets. In these circumstances, although GPs will have the freedom to remain as self-employed contractors, many may give that up to become salaried employees.

Up to 80 per cent of graduate medical students have indicated that, to enjoy flexible career paths, they would prefer to be salaried GPs than independent contractors.

This may help overcome the recruitment crisis in general practice, but it undermines the principle of the independent contractor. If the powerful GPs' lobby is forced to comply with government policies, how will other professions with weaker representation fare in resisting changes?

In such circumstances, chief executives of PCTs may consider buying pharmacies to improve integration of primary care by employing GPs, pharmacists, nurses and others as part of a multidisciplinary team.

Apart from better integration of services, this would also improve management of resources and patient outcomes.

A number of benefits could accrue from such models. These include an integrated primary and community care structure with local 'command and control' systems.

The PCT will also be able to claim that it is discharging its duties relating to management of finance and personnel in a cost effective manner.

A viable future

What will community pharmacists have to offer to remain as independent contractors, with a viable future, operating outside the PCTs? How will community pharmacists convince PCTs and Social Service purchasers that their services are worth buying?

A search for radical solutions, combined with local devolution of funds and decision-making will not respect professional boundaries for long. The transition to managed care, UK-style, will involve significant changes in approach, particularly for those working in GP surgeries. But it will also impact on those they come into contact with.

Local pharmaceutical committees will have to work out ways of representing all contractors in their area when there is a mad scramble for service contracts. Nurses and GPs may also have ambitions for the same monies.

There are important issues to be addressed quickly. These include:

- new systems of working
- networking and team-working
- information management
- people management – competition vs co-operation
- clinical service planning and delivery
- training and development.

Most importantly, an understanding of health needs identification, the development of practice profiles, and a local strategy planning mechanism are needed now if pharmacists are to play a significant role in the new NHS.

This may sound a bit academic, but pharmacy contractors should be wary of an aggressive confidence that belies our serious handicaps in a number of key areas.

These handicaps call for strong, effective and well-informed leadership. Will pharmacy contractors and their representatives adapt in time?

Time is of the essence

Immediate action is needed if the profession is to figure in the new NHS, pharmacists have been told.

Barking & Havering Local Pharmaceutical Committee secretary Hemant Patel warned: "We have to do something now rather than wait for tablets of stone to appear." He is concerned that the new NHS is progressing quickly, but awareness among pharmacists about the changes remains low.

Contractors are confused about the changes, which "are revolutionary, not evolutionary". They need to be made aware that these changes will happen and that they need to be involved, said Mr Patel.

The health White Paper promotes the idea of a 'framework' to replace a 'blue print'. "When the NHS was set up, people had to do everything in the blue print, but the framework allows initiative at a local level," he explained. With the NHS allowing for experimentation, "we should not be afraid to take risks".

One of the priorities Mr Patel sees for the LPCs is for them to build awareness in contractors of the new NHS. Ways must be found to interest pharmacists in both their own and the LPC's development as the changes progress. As such, Mr Patel says that the LPCs should work with those who do want to adapt and build a critical mass of at least one fifth of contractors who are willing to adapt.

Action should be prioritised to look at professional values, such as improving public and other professions' view of the pharmacy service. Practice needs to be based on evidence with investment in R&D. And by working with others, such as GPs, nurses and health economists, better evidence can be gathered.

Health needs should be identified locally as should links between health and social services and other local participants. Communication skills should be developed – especially when more money will go to those who can present their case well, believes Mr Patel.

With information management, it is important for pharmacists to understand how financial and activity information can be brought together. The LPCs should also try to influence the gathering of pharmacy specific data.

One of the key changes is that the individualisation of care will develop. As such, it is important to look at the health and social care objectives together. "The emphasis is on health, not health care." This means that preventative measures will exert a greater influence in the future.

With the number of health authorities being reduced – in England and Wales there will be 45 instead of the current 105 HAs – and new boundaries formed, LPCs will also change. In addition, HAs will hand down

tasks to the new bodies, especially the primary care groups.

GPs will have to prescribe according to budgets and local protocols, meaning the emphasis will be on clinical governance, as opposed to clinical freedom. PCGs will have one 'all-inclusive' budget which will be capped. Therefore, GPs will have to manage their budget within given limits and will seek pharmacy input on prescribing costs.

Additionally, there will be further moves by the government for better integration of health and social services. LPCs should, therefore, be looking now at what the social service objectives are. At a national level, guidance will be issued and there will be a statutory duty of partnership to meet the local population.

Information can empower the pharmacist in the new NHS, says Ian Shepherd, head of the RPSGB's information technology policy development unit: "The key to it all is the electronic patient record. It doesn't matter where it is held, so long as we can get to it when we need it." He added that IT must be a financial priority for pharmacy. It is unlikely that NHS money will go to pharmacy to upgrade its IT systems. "Pharmacy IT is funded by ourselves. I do not believe that will change," he said

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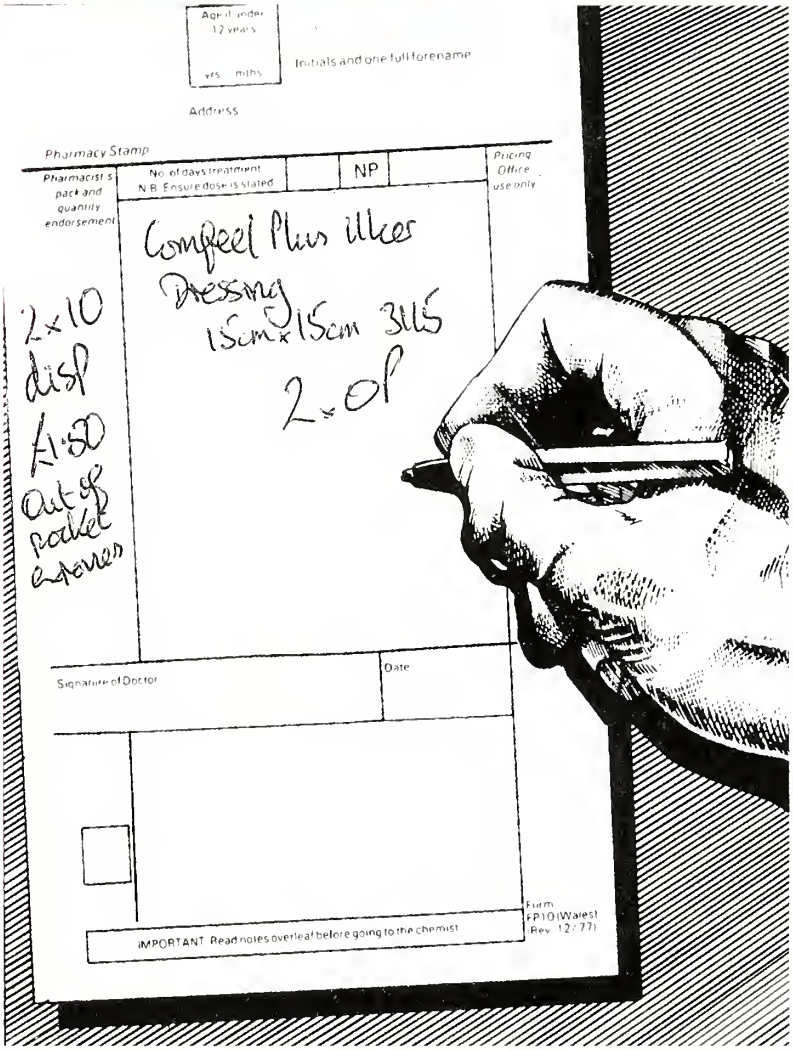
Marketing Authorisations: Senokot Tablets 0063/5000R, Senokot Syrup 0063/5003R, Senokot Granules 0063/5002R. **Supply Classification:** Through registered pharmacies only **Holder of Marketing Authorisations:** Reckitt & Colman Products Limited, Dansom Lane, Hull HU8 7DS **Date of Preparation:** 11 December 1997. Senokot and the sword and circle symbol are trademarks.
References: 1. IMS Data BPI Oct 1997



Confusion over how many dressings this patient was entitled to saw the pharmacist dispensing 20 dressings. Was he right to do so? The Pharmaceutical Services Negotiating Committee explains...

Questions

1 How many dressings would be priced?

2 How would this prescription have to be written for 20 dressings to be priced?

3 Can out-of-pocket expenses be claimed on dressings?

Answers

1 Two singles. As they are priced per piece in the Drug Tariff, an OP = 1.

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Hearing clears director

A company director accused of misleading a clinic he supplied with hair restorer by using the letters 'MRPharmS' after his name, was cleared at a hearing last month.

Ivor Dennis Sherman, of Whitchurch Lane, Edgware, was thought fit to be restored to the pharmaceutical Register after being struck off in October 1996.

Accusations against Mr Sherman, a director of Wm G Carter (Pinner) Ltd, trading as Carters Pharmacy of 41 Salisbury Road, Eastcote, Pinner, were made in an anonymous letter sent to the Royal Pharmaceutical Society, which was considering his application to rejoin the Register.

The Statutory Committee dismissed the accusations. It accepted that an invoice bearing Mr Sherman's name followed by 'MRPharmS' was either a doctored document or was an oversight by his wife.

A fax from the Svenson Clinic in Manila gave the Committee proof that the minoxidil powder to promote hair growth exported by Mr Sherman to the Philippines was used under medical supervision.

The Committee also accepted that Mr Sherman was only a director – not a supervising pharmacist – and so not responsible for deficiencies in labelling and weighing of products in the pharmacy.

Additionally, the Committee believed Mr Sherman's evidence that he had merely delivered, and not sold from his home, a bottle of anti-balding lotion to a neighbour.

Course helps to restore fortunes of pharmacist

A pharmacist, struck off for pocketing the difference when he billed the NHS for more expensive medicines than he actually dispensed, was allowed back on the pharmaceutical Register last month.

Rashmikant Vora, of Plumstead, was struck off, following a hearing in April 1992, for nine charges of overcharging for the supply of opioid analgesics.

Following the instructions given by the Statutory Committee of the Royal Pharmaceutical Society on October 21 last year, he went on a 30-hour 'return to practice' course at Nottingham University.

He said he had been off drink and drugs since attending a rehabilitation centre in 1995. A representative from the rehabilitation centre told the hearing: "I have every confidence he is clean and sober and his attitude is right as well."

Dobson launches NPA's NHS 50 competition

Health secretary Frank Dobson has launched the National Pharmaceutical Association's competition to celebrate the NHS' 50th anniversary. Commenting on Monday's launch at the Star Pharmacy in Westminster, Mr Dobson said: "A quick look at the mainly light hearted quiz shows the impressive range of knowledge available free of charge, close to home, from your local pharmacist." Below: Frank Dobson (right) is pictured with pharmacist Mustakali Kurji

Ex-drug addict returns with right attitude

A former drug addict and pharmacist, struck off in September 1996 after admitting he was responsible for 3,600 amphetamine tablets going missing from his pharmacy, has been allowed to return to practice.

Roger Pilling, of Fulwood, Preston, who was accompanied by his wife at last month's Statutory Committee hearing, said he had been working at his pharmacy with a supervising pharmacist for three days a week and had been attending Alcoholics Anonymous meetings twice weekly.

Networking to find ideas that pay

Two significant factors that affect pharmacists' reimbursements in the States are causing many of them, particularly independents, to turn to each other for help.

These factors are:

- the steady increase in third-party pay prescriptions, which now make up almost 80 per cent of all scripts dispensed
- the continuing downward trend in reimbursement for the core dispensing function.

As these two factors continue to reduce overall gross margins for pharmacy businesses, US pharmacists are pushing hard to find new ways to win reimbursement for 'services' – those aspects of practice other than the dispensing of medication.

Because pharmacy practice is undergoing change at a great rate, new patient-management opportunities are constantly emerging. Sharing information and insights about these issues is crucial for pharmacists.

This becomes extremely difficult when many practitioners are geographically or structurally separated from each other.

To assist pharmacists in learning from each other about reimbursement for patient care, the American Pharmaceutical Association (APHA), the States' largest pharmacy practice trade group, has launched a 'Networking Directory'.

This is basically a listing of pharmacists around the country who are involved in specific areas of patient care and are, in one way or another, seeking or receiving reimbursement for it.

The directory is set up in such a way as to clearly identify the pharmacist involved and the specialty that he or she is involved in, followed by complete contact information. The fact that a pharmacist is listed indicates that he or she is willing to share information with other pharmacists from around the country.

The directory is published quarterly by the APHA Foundation and is distributed to the entire APHA membership, more than 50,000 practising pharmacists located in all 50 states.

Alternative medicines receive mass attention

As pharmacists search for new profit centres, particularly in the OTC/front shop area, much attention is being paid to nutritional and alternative medicines.

These categories include:

- 'traditional' vitamin supplement products
- herbal and homoeopathic remedies
- new, 'trendy' items, such as St John's Wort and glucosamine, publicised as 'alternative medicines'.

While the industry as a whole is difficult to quantify, it is estimated that more than 75 per cent of all Americans take vitamin supplements of one kind or another, and that this number will be over 90 per cent by the year 2000.

This translates into a marketplace of more than $6bn for vitamins alone, about 50 per cent of which are sold in pharmacies.

As far as the other categories are concerned, they are much harder to track and quantify – there is a vast 3,000 store network of 'mom and pop' health food shops in the US, most of which are even difficult to locate.

This group has been instrumental in supporting the 'alternative medicine' wave sweeping the country. However, it is obvious that pharmacy, with more than 57,000 outlets, is the retail entity to drive it to the next level.

Pharmacies around the country, both multiple and independent, are getting more and more involved in these product categories. They are increasing display space, using new merchandising techniques and, when appropriate, educating staff, consumers and other health care professionals as to the benefits of nutritional supplements and alternative medicine.

PBMs to be reined in over 'therapeutic switches'

The Food & Drug Administration has announced that it plans to keep a tight rein on medical product 'switching' activities, more commonly known as 'therapeutic substitution'.

This practice, developed and fine-tuned by Merck-Medco, the mail order and pharmacy benefits management (PBM) giant owned by Merck, is one in which clinical pharmacists staff large banks of telephones, and call physicians to ask them to switch products within a therapeutic category.

While the practice is primarily one used in the mail order pharmacy environment, it can, and is, being used at retail level. The products offered for a switch can be alternative brand name products or generic alternatives.

A draft guide clarifying the FDA's policy regarding promotions by PBMs and similar enterprises owned or influenced by drug companies (the three largest PBMs in the country are owned by pharmaceutical manufacturers), has discussed the switching issue in some detail.

It noted that the practice could have serious health implications for patients, particularly for those dependent on chronic therapy, if medical decisions are unduly influenced by incorrect or misleading information.

The guide addresses activities of manufacturer-owned PBMs and others that have arrangements with drug firms to pay them 'marketshare rebates' if they can influence prescribing and/or dispensing decisions.

In examining these activities, the FDA will consider the nature and extent of a PBM's ties to any drug or device manufacturer, and the role the company plays in assisting a PBM in promotional activity.

The FDA first examined this issue as long ago as 1995. At that time, firms without a PBM 'connection' complained that they were at an unfair disadvantage, when it came to promotion of their products in certain third party plans managed by the PBMs.

If adopted, the FDA's plan would include a review of all PBM promotional material and 'clinical' activities, to make sure that manufacturers are not disadvantaged, and that patients are receiving the medication prescribed by their physicians, subject to formulary compliance and other substitution regulations.

Financial losses by managed care companies spell trouble

Reports of negative financial performance by many US managed care companies and health insurers will no doubt spell trouble for US pharmacists in 1998.

Recently, a number of the largest of these publicly-quoted firms have reported poor financial results – primarily, significant operating losses – due to a number of factors, including:

- inability to keep pace with enrolments, due to the addition of Medicare and Medicaid patients to the managed care environment
- the need to upgrade outmoded computer systems which monitor both premiums and payments to providers.
- rising health care costs, particularly of drugs.

The last point will obviously impact on pharmacists. While total health plan costs rose negligibly in 1997, the cost of prescription drug coverage increased by 5.9 per cent among large employers that have 'carved out' this element, and contracted with a pharmacy benefits manager.

A recent survey found that the growth in total health plan costs for active and retired workers of public and private sector employers, with ten or more staff, was held to 0.2 per cent, yet the cost of drug benefits continued to rise.

While this is primarily due to the high cost of new products, rather than increased reimbursement, it is obvious that managed care entities and third party payers will look to pharmacists to help contain these costs, thereby putting pressure on already reduced fees and reimbursement.

The only other place that these companies can go to reduce pharmacy costs is to the patient. This might be accomplished by raising co-payments and/or reducing drug benefits. However, with the competitive pressures on HMOs to increase those benefits, it is doubtful that much will be done.

Manufacturers are not yielding to pressure for larger rebates and lower drug costs, as they continue to learn that HMOs are not always able to control physicians' prescribing habits.

Intelligent physician promotion and constant pressure on formulary and therapeutics committees to include new, high cost drugs in managed care programs make it difficult for HMOs to exclude these products.

Vanguard Medica in £5m drug deal with Stiefel Laboratories to market psoriasis treatment

Vanguard Medica has signed a deal with Stiefel Laboratories (SL) to develop and market VML 262, a psoriasis treatment.

SL will help pay for the compound's preclinical programme and offer milestone payments that could top $8m ($5m) over five years. Vanguard will receive royalties on VML 262's sales.

In return, SL will obtain the rights to market the compound in the EU and Latin America.

VML 262's Phase II trial, being handled by Vanguard, began in February and is expected to run until late 1998. SL will take over the compound's development for Phase III.

Vanguard will look for other partners to market the drug in North America and remaining worldwide markets when it receives its Phase I results.

Robert Mansfield, Vanguard's chief executive officer, says SL's dermatology skills will help VML 262's progress. "Stiefel has excellent research facilities for formulation development in the UK, the US and Brazil, and a strong manufacturing, marketing and selling network servicing the key countries of the licensed territories," he adds.

The news comes as Vanguard nearly doubled its loss to $21,158m for the year to December. Most of that stemmed from the company's R&D costs. The company's turnover rose 160 per cent to $1.5m.

Its biggest project – frovatriptan, an oral treatment for acute migraine being developed with Smithkline Beecham – is expected to yield Phase III results in the Spring.

Unichem sponsors Great Business awards

Alliance Unichem is sponsoring 'Great Business' awards, to highlight innovative and successful independent pharmacies.

The awards are divided into four categories: traffic generating initiatives, building relationships in the community, innovative new retail outlet and recent acquisitions.

Entry forms are available in this week's issue of *C&D* and this month's *Community Pharmacy*.

Each category winner will receive £1,000 towards a holiday of their choice, while the overall winner will be given two free places on Unichem's 1999 convention.

Independent pharmacies can vote for the most supportive drug manufacturer.

'Wholesale margin is safe'

The government has confirmed it has no plans to cut the drug wholesale discount rate from 12.5 per cent to 8 per cent.

On Monday, the British Association of Pharmaceutical Wholesalers (BAPW) sent a circular to its members saying that neither the Department of Health or the Treasury aim to cut the margins.

The BAPW had warned the government last month that the proposal, if adopted, would have disastrous effects: wholesalers' discounts to pharmacies would be cut; wholesalers would also have to reduce the services they offer. More than 2,000 pharmacies could close as a result, it added.

Mike Watts, BAPW's executive director, says the DoH moved quickly to defuse the situation, after it saw the depth of feeling in the pharmaceutical industry.

Over the past two weeks the BAPW has had calls from pharmacists around the country and from manufacturers who wanted to know where they stood under the proposal.

While the DoH is still keeping wholesale margins under review, as it normally does, Mr Watts says it understands the underlying issues a lot better now.

Jeff Harris, BAPW's chief executive welcomes the news. "It's the most pleasant surprise we've had for some time – with negotiations for the Pharmaceutical Price Regulation Scheme still carrying on, another uncertainty has been removed," he says.

Boots to pilot new store sites

Boots is trialling a pilot store in Southampton hospital and at a motorway station on the M6.

Its hospital outlet does not have an NHS contract and supplies products patients would not receive in hospitals, such as moisturisers and toothbrushes. The store also stocks OTCs.

Boots pilot on junction 10 (A) of the M6 stocks OTCs and travel-related products, including ear plugs and camera films.

Changes to waste packaging 'unfair'

Possible amendments to waste packaging regulations could be grossly unfair to pharmacists, according to the National Pharmaceutical Association.

The NPA is lobbying the Department of Environment, Transport and the Regions (DETR) after it sent out a consultation document on the regulations to assess companies' views.

The NPA has told the DETR that a firm's waste packaging responsibilities should not be judged on its total turnover. This criterion would place a waste packaging burden on many pharmacies out of all proportion to the amount of waste they produce.

And more pharmacists would have to deal with waste packaging, particularly when the turnover threshold is lowered to £1m in 2000.

The DETR also assesses firms' waste packaging on the amount of packaging they handle each year. Containers such as tablet bottles, which are exempt from the recovery and recycling obligations, says the NPA, should not count towards the threshold amount of packaging handled each year.

It is unreasonable, it adds, to expect pharmacists stocking around 2,000 product lines – all of which have different packaging – to calculate the amount handled each year. Manufacturers, who are responsible for the packaging, should assume most of the obligation for its recovery and recycling. They should also supply wholesalers with estimates of the weight of waste involved.

Shares in Chiroscience leapt 23 per cent, earlier this week, on the announcement that the company has licensed its long acting local anaesthetic to Zeneca on an exclusive worldwide basis (excluding Japan). Chief executive John Padfield (above right, with finance director Christine Soden) says the deal should bring in £200m in revenue for Chiroscience. As a separate part of the deal, Zeneca, the UK's third largest pharmaceutical company, is investing £15m for a 3.17 per cent stake in Chiroscience in newly issued shares. Chirocaine (levobupivacaine) may be launched in European markets later this year

Warner-Lambert to close Pontypool plant

Warner-Lambert is closing its 44 acre Pontypool plant with the loss of 311 jobs.

Its decision follows a recent review, which said the plant's production should be transferred to other WL sites. WL began to scale down the plant's activities in 1992 as it restructured its European production to deal with the removal of trade barriers.

The plant's main products are Benylin, Listerine and Remegel chewy indigestion squares.

Benylin's production will be switched to WL's plant in Orléans, France, while the company's US plant in Pennsylvania will produce Listerine. A contract manufacturer will probably produce Remegel.

Most of the redundancies will occur next year. WL is offering various initiatives, such as an on-site job shop to help the employees find work elsewhere.

"It is a sad day for Pontypool, but I hope that by making an immediate announcement, my colleagues, who have lived with uncertainty for a long time, can now begin to plan their futures," says a WL spokesman.

- WL has raised its stake in Xenova, the biotech company, to 3 per cent, after it bought 457,584 shares worth $1m. Its purchase follows Xenova's successful pilot phase of QTC, a drug discovery programme the biotech company is conducting with Parke-Davis, WL's pharmaceutical division.

Trade union rejects JIC pay offer

The National Joint Industrial Council for Retail Pharmacy (England and Wales) has failed to agree a pay increase for shop assistants and dispensing assistants.

Employers offered a 2.9 per cent increase when the JIC met on March 12, but that was rejected by the trade union side.

Glyn Walduck, representing employers, says the trade union side would not settle on an increase below the inflation rate of 3.3 per cent.

"We offered as much as we could reasonably offer, given that contractors are being pegged back," he says.

Employers have no plans to meet the trade union side again to re-negotiate.

Mr Walduck says JIC rates are merely a guide. As the rates are no longer part of employees' terms of service, he adds, contractors can opt not to adhere to them. "It's up to employers to decide how much they want to pay their staff [now]," he says.

● A National Minimum Wage (NMR) of £3.50 per hour – the figure favoured by most commentators – would cost the community pharmacy sector £28.6m, according to the National Pharmaceutical Association.

The NPA has sent the estimate and a list of other NMW concerns to the Low Pay Commission. The NMW bill has moved to the House of Lords – its potentially damaging impact on the community pharmacy sector was mentioned during the second reading.

Numark rebates reach £1.3m

Numark's total rebates last year were worth a record £1.3m – its fourth quarter rebate of £460,000 was more than those of the first and second quarter combined.

The society says its fourth quarter rebate represents about £400 per pharmacy, which is a 100 per cent return on the management fee.

Numark's membership, meanwhile, has risen to 1,115 pharmacies and it says it is on target to reach 1,250 by the end of the year and 2,000 by 2001.

Its AGM will be held at the Slieve Donard Hotel in Newcastle, County Down, Northern Ireland, on May 16-17.

Drugs lift Novartis sales

Drugs were one of Novartis' best performing areas as its net income last year leapt 43 per cent to Sfr5.211bn ($2.08bn) on sales of Sfr31.18bn.

This was the group's first financial year – it was formed in 1996 when Ciba Geigy merged with Sandoz Pharmceuticals.

Novartis' drug sales grew 11 per cent to Sfr14.112bn on the back of "outstanding" performances in the US and good results in Spain, France and Brazil.

Its best-selling products Sandimmun and Neoral, which treat transplantation and autoimmune diseases, saw their combined sales rise 8 per cent to Sfr1.82bn.

Sales of Voltaren, an antirheumatic, rose 4 per cent to Sfr1.605bn. But the group's best performer was Lamisil, a treatment for fungal nail and skin infections, whose sales jumped 53 per cent to Sfr912m.

Diovan, the antihypertensive launched last year in 35 countries, achieved sales of Sfr116m.

Strong drug sales and improved productivity raised Novartis' health care margins by 2.1 percentage points to 26.7 per cent.

Novartis' health care division, which includes drugs, accounts for 60 per cent of its sales.

'VAT is a headache for small firms', says Barclays Bank survey

Small businesses rate VAT as their biggest administrative burden, according to a Barclays Bank survey.

Thirty nine per cent of the businesses say VAT is an administrative headache, ahead of late payment, self assessment and health and safety regulations.

And 19 per cent – particularly in the retail, property, hotel and catering sectors – say that completing VAT forms is the worst administrative task. About 19 per cent also say the main problem is finding the money to pay their VAT bills, while others say VAT forms are too time consuming.

Around 15 per cent say it is a chore to ensure they have the correct receipts.

The survey covered a nationally representative sample of 255 small businesses whose turnover was less than £500,000.

Barclays says VAT forms will be less of a problem if small businesses:

- set aside money for VAT payments in an interest-bearing account, which will ensure the funds are available when the VAT bill is due
- develop an efficient record-keeping system which includes details of tax invoices, purchase records and credit notes. These records should be kept for six years, in case a VAT inspector wants to see them
- if in doubt about how to fill in your VAT return, or if you need information about new regulations, talk to your accountant or local business support organisation, such as Business Links.

● The government has launched a ten point action plan to end unnecessary red tape in Europe. Its proposals include a pilot European business test panel, which will ensure businesses can comment about EU rules being developed.

● Business Links (BL) has begun to measure how far it helps its clients, in terms of increased profitability, turnover, exports, sales and employees. BL's standards are also being improved with new accreditation criteria covering five key BL areas.

Boehringer Ingelheim redevelops in UK

Plans have been announced to redevelop Boehringer Ingelheim's UK head office at a cost of £50 million.

Work has already started at the Bracknell site, which is being expanded to accommodate all staff and production requirements well into the 21st century. The project should be completed by 2000.

Boehringer Ingelheim's UK workforce will grow to around 700 by the end of this year, reflecting the expansion of the company to produce unit dose vials. Nearly 80 per cent of the corporation's UDV output is produced in the UK for export to Europe, Asia and Canada.

ADVANCED INFORMATION

The **College of Pharmacy Practice** is holding a college day seminar in Dunchurch, on **April 30**. 'Prescribing and Supply – A time for change'. Tel: 01203 692400.

UK Association of Pharmaceutical Scientists meeting on 'The consequences of *in vitro* predictions to humans' at the University Arms Hotel, Cambridge, on **April 30**. Call 01784 464106 for details.

The **1998 Vantage Convention** will be held at the Grand Hotel in Stockholm on **May 7-10**. Contact Nina Wheeler/Sue Buckley at Harrison Cowley. Tel: 0161 437 4474.

The **UKCPA** is holding a residential symposium 'Progress in Practice', on **May 8-10**, in the Queen's Hotel, Leeds. Contact: Mrs Pat Kennedy, tel: 0116 277 6999

Nucare plc is holding its 3rd Annual convention on **May 15-17**, at the Forest of Arden Hotel, Meriden, Warwickshire. Details from Nucare, tel: 0181 515 9800.

The **British Association of Pharmaceutical Physicians** is holding a three-day residential workshop on **May 19-21**, at the Swan Diplomat Hotel, Streatley-on-Thames, Berkshire. Contact Pauline Aban of BAPP, tel: +44 (0) 171 491 8610.

AESGP, the European Proprietary Medicines Manufacturers' Association is holding its 34th Annual meeting on **May 20-23**, in Athens, Greece. Contact: AESGP, in Brussels, tel: (322) 735 51 30.

The **United Kingdom Clinical Pharmacy Association** has organised a study day on **May 28** at the Quality Cobden Hotel, Hagley, Birmingham – 'Paediatric Intensive Care'. Contact: Mrs P Kennedy, tel: 0116 277 6999.

'Informed drug prescribing' conference on **April 22**, at the Conference Forum, The Sedgewick Centre, London E1. Contact: BJHC. Tel: 01932 821723.

Pharmaceutical Marketing Society debate at the Reform Club, 104 Pall Mall, London SW1, on **April 22**. 'The bottom line - clinical effectiveness or cost'. Contact Jenny Botsford. Tel: 0171 937 1132

The **National Association of Senior Pharmacy Manager's** open forum at the Royal Pharmaceutical Society of Great Britain, 1 Lambeth High Street, London SE1, on **May 6**. Alan Ross, tel: 0161 773 1726.

COMING EVENTS

MONDAY, APRIL 6

Derby Branch, RPSGB
Postgraduate education centre, Kingsway Hospital, Kingsway, Derby, at 7.30 for 8pm. 'Question Time Panel on new White Paper'.

Southampton Branch, RPSGB
BUPA Chalybeate Hospital, Tremona Road, Southampton, 7.30 for 8pm. Annual General Meeting and wine tasting – 'Wines in a New Age'.

WEDNESDAY, APRIL 8

NICPPET
Hillsborough. Subject: 'Eye Disease'.

THURSDAY, APRIL 9

Lanarkshire Branch, RPSGB
The Old Mill Hotel, Motherwell, 8pm. Annual General Meeting and dinner.

NICPPET
Belfast. Subject: 'Emergency first aid' (pre-registration students).

Classified

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TRADE LESS 40%+VAT - 8 Nuvelle TS Patches (exp 12/98), 48 Dalacin C 150mg (exp 7/98). Tel: 01269 850302.

TRADE LESS 30%+VAT - 222 Lopid 300 (exp 1/00), 188 Neurontin 300 (exp 1/99), 128 Lamictal 25mg (exp 9/98), 146 Lamictal 50g (exp 11/98). Tel: 01276 33819.

TRADE LESS 25%+VAT+POSTAGE - 35 Fortum inj 1g (exp 5/99). Tel: 0171-274 4591.

TRADE LESS 40%+VAT - 101 Adizem SR 120mg caps (exp 1/99). Tel: 0181-592 4904.

TRADE LESS 50%+VAT+POSTAGE - 56 Zyprexa 7.5mg (exp 7/98), 200 Pen-

EXCESS STOCK CAUTION

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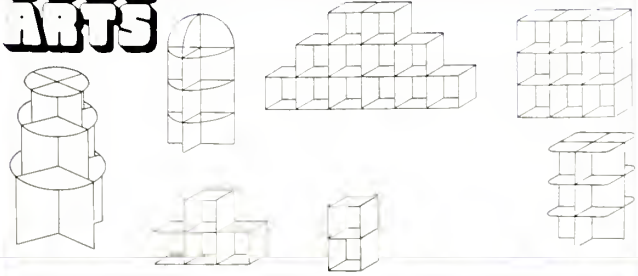

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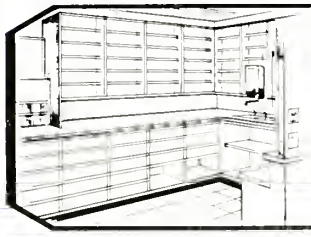

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ABOUTpeople

'World's Toughest Yacht Race' beckons pharmacist

Andrew Magrath at his induction for the 'World's Toughest Yacht Race'

Locum pharmacist Andrew Magrath from Tamworth, Staffordshire, is planning to fulfil an ambition which will take him 30,000 miles around the world.

He has been accepted as a crew volunteer in the 'World's Toughest Yacht Race' in which up to 15 72ft yachts with crews of 18 will sail the wrong way round the world, against winds and tides.

The fleet leaves Southampton in September 2000 and will cross the Atlantic to the US, then it will head south to Rio de Janiero. After negotiating South America's Cape Horn, it will proceed to New Zealand and Australia.

From here, the yachts will cross the Southern Ocean to Cape Town in South Africa, and then make their way back to Great Britain. The journey will take about ten months

This experience does not come cheap. Andrew has paid two $3,000 instalments towards the $25,000 berthing fee, and is on the lookout for sponsorship.

"This is something I've always wanted to do. I started sailing when I was eight and wished I could go on the Whitbread round the world race, but it is only for professional sailors. When I saw this opportunity for amateur sailors, I thought I'd give it a go," says Andrew.

He attended a five-day induction course in freezing cold conditions and gale force winds last December, and will train for a further four weeks before the race.

As yet, he does not know what boat he is on or who the rest of the crew will be. Anyone wishing to sponsor Mr Magrath can contact him on 01827 63024.

PSNI fellowship presentation

Over 100 pharmacists and guests attended the presidential dinner of the Pharmaceutical Society of Northern Ireland, held at the Culloden Hotel in Belfast last Saturday. Among the guests were Mr Michael Durcan (left), president of the Pharmaceutical Society of Ireland, and his wife Anne, with vice president of the PSNI, Dr Terry Maguire

The presidential dinner of the Pharmaceutical Society of Northern Ireland was a particularly memorable evening for Sally O' Kane, who was awarded her fellowship certificate by president of the Society, Dorothy Graham.

Sally registered as a pharmacist in 1962 and for the past 30 years has worked in the Altnagelvin area hospital as deputy chief pharmacist, principal pharmacist and director of pharmaceutical services. She is the only director of pharmaceutical services in Northern Ireland with responsibilities for a hospital trust and a health board.

Sally is currently chairperson of the central pharmaceutical Advisory Committee, to which she was appointed as an inaugural member in 1974. As a member of the postgraduate pharmaceutical and training committee, Sally has helped develop education programmes for pharmacists throughout Northern Ireland.

Ms Graham said it was her pleasure to award the certificate to Sally, who has worked tirelessly for the pharmacy profession in Northern Ireland.

In her acceptance speech, Mrs O'Kane spoke of the serendipity that had led her into a 'nice clean job for a girl' as it was judged at that time.

New Fellow of the PSNI, Sally O'Kane, at the presidential dinner with her husband Bernard (left) and Ronnie McMullan, director of the pharmaceutical Services Central Services Agency

APPOINTMENTS

The Royal Pharmaceutical Society has appointed **Miriam Harris** as a research manager in the professional development department. She will work with Dr Sue Ambler, head of practice research.

Lars Stork has joined Coty, from Elizabeth Arden, as executive vice president of operations, while **Michael Simpson** has replaced **David Allan** as Coty UK's marketing director for fragrances. Mr Allan has been promoted as international marketing director.

AAH hospital service has promoted **Karen Wharfe** to the position of hospital service manager for its Warrington branch. She was previously a customer service manager in Runcorn.

Dr Peter Read and **Dr Marvin Jaffe** have been appointed by Vanguard Medica Group as non-executive directors, replacing Sir John Vane and Dr Andre Lamotte.

Pharmacist Gwyn Morris from Cefa Glas Pharmacy in Bridgend was the winner of a pharmacy karting competition in Cardiff on March 4. Over 50 pharmacists competed in the race organised by Medihealth, which is planning further events elsewhere. Alan Rees of St Treharne Pharmacy in Bridgend and Martin Davies of Danes Pharmacy in Newport came second and third respectively. Medihealth's area sales manager, Steve Matthews (right), is pictured presenting Mr Morris with his award

Overdue reunion for 'Square' graduates

Pharmacy and toxicology graduates and lecturers from the School of Pharmacy, London, are being invited to attend the first official Square reunion in over 20 years.

Eight years ago, there was a private reunion of Square pharmacists who graduated between 1955 and 1960, but an official get together has not occurred for at least 23 years, according to SOP's Dr Cheryl Hemingway.

The informal affair, which includes snacks and a disco, is set to take place at Brunswick Square on May 30, starting at 6pm. The SOP bar has been granted an opening extension until 1am.

Dr Hemingway is expecting about 200 people to attend. For further details, she can be contacted on 0171 753 5800 x 4877 or 0171 753 5883.

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